REPORT OF THE DOWNSTATE COMMUNITY ADVISORY BOARD

Transmitted June 4, 2025, to the Governor,
the temporary president of the senate,
and the speaker of the assembly

Table of Contents

Introduction

SUNY Downstate has a rich history as a center of medical education, research, and clinical care – training a Nobel Laureate, advancing medical innovations, and addressing health inequities. At its peak, the hospital was near full capacity, serving a bustling and diverse patient population. Over the decades, however, there have been many significant shifts, and the surrounding community continues to experience some of the poorest health outcomes in the state. SUNY Downstate, as well as other Brooklyn hospitals in the area, have faced mounting and persistent financial deficits. Many reports have been written proposing solutions, but the challenges remain.

The community faces extensive health challenges. Approximately 60% of Brooklynites have one or more chronic diseases. The community experiences high rates of maternal and infant mortality. The top two leading causes of death among Brooklyn residents are cancer and heart disease. A shortage of primary and preventive care in the borough contributes to avoidable hospitalizations and probable premature and excess deaths.

SUNY Downstate hospital is highly valued by the community, and it provides a broad array of important inpatient services including some unique services like kidney transplants. The hospital also provides outpatient services and is one of two regional perinatal care centers in Brooklyn. As a safety-net hospital, Downstate helps address health inequities in an underserved community.

Downstate Health Sciences University is comprised of five schools and colleges including the College of Medicine, College of Nursing, School of Health Professions, School of Public Health, and School of Graduate studies. The medical school is the largest in New York City and is consistently one of the top three largest in the State. Downstate had the most underrepresented in medicine (URiM) medical school graduates in NYS in the class of 2023. Most physicians trained at Downstate remain in New York State.

Governor Hochul and the state legislature created the Downstate Community Advisory Board (DCAB) for the modernization and revitalization of SUNY Downstate in the SFY2024-25 State Budget. DCAB is charged with recommending a reasonable, scalable, and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate using $750 million in capital funding. The last two State Budgets, SFY2024-25 and SFY2025-26, provide up to $100 million each year to address the hospital operating deficits.

DCAB embraced and welcomed the opportunity to hold four public hearings to ensure community voices were heard. Residents within Downstate's service area were encouraged to attend and participate by either speaking at the hearings or submitting written statements. Two hearings were held in Community Board 9 and two in Community Board 17.

Public hearings were well attended, and DCAB heard the community express their reliance on and trust in Downstate's valuable healthcare and education services. Although DCAB consultants emphasized from the outset that closure was not under consideration, and the Governor made that clear in a video at the first hearing, it remained the most frequently raised concern by participants.

Throughout every public hearing, the Downstate Community Advisory Board (DCAB) consistently heard the community express its strong desire for Downstate inpatient services to be preserved. At the hearings there were also individuals that stressed improvements are needed in the quality of care, patient experience/customer service, and culturally competent healthcare delivery. Overall, there has also been strong support for the work that the University does to train a diverse healthcare workforce.

Additional input included suggestions regarding the types of services the community felt they needed most and proposals like the Brooklyn for Downstate's new hospital. Many speakers shared personal stories about their experiences, both positive and negative, as patients, students, faculty, staff, and community leaders.

DCAB was dedicated to developing the best path forward for SUNY Downstate given the resources that were made available. The resulting DCAB recommendations are supported by the majority of advisory board membership.

There are members of DCAB that believe additional resources should be allocated and prefer other options be considered to address SUNY Downstate and the community's needs if additional funding becomes available.

This report fulfills DCAB's statutory charge and incorporates community input, presents a thorough review of the complex infrastructure, market, financial and structural issues, and builds on SUNY Downstate's existing strengths. The recommendations contained in this report will help chart a path forward for a stronger SUNY Downstate and a healthier future for the Brooklyn community.

DCAB Recommendations

DCAB is charged with recommending a reasonable, scalable, and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate. The available capital funding makes it possible to maintain existing inpatient and outpatient services at Downstate, dramatically renovate the current hospital, and build a new state of the art ambulatory surgery center.

From review of the data, analyses, and what was heard from the community and leaders of Downstate and other institutions, any viable path forward will require the following changes in leadership and operations to support success. Regardless of what recommendations the State decides to implement, the following are essential to Downstate's future.

Leadership, Operations, and Collaboration

Hospital and Campus Accountability & Culture

While a more modern infrastructure is essential to improve payor mix and market share, it is equally appropriate to ensure clearly defined expectations from campus and clinical leaders and hospital administration as the transformation plan is implemented.

SUNY Downstate faces internal challenges related to management and institutional culture, accountability, and the separation between the hospital, academic campus, and clinical practice plan oversight. Efforts must be made to better support integration, alignment, oversight and responsibility.

Any implementation plan should have well understood goals, targets, and key performance indicators (KPIs) measuring progress. These KPIs should be related to achieving the targets assumed in financial projections, productivity, quality, customer service/patient satisfaction, and more.

Acquire New Electronic Health Record (EHR) System

SUNY Downstate hospital currently uses Altera electronic health record (formerly Allscripts) for inpatient services and Downstate physician practices run on 9 different electronic medical record systems. There are multiple other disconnected or loosely connected related systems (revenue cycle, referrals, scheduling, etc.). This situation results in inefficiencies in patient communication, availability of medical information, referrals and billing.

Modernization at Downstate must extend beyond the hospital building to include its information systems. The current outdated and fragmented electronic health records and other systems significantly hinder operations, reduce revenue, lower patient satisfaction, and in some case may compromise patient care.

DCAB recommends that a new EHR is acquired to optimize billing and scheduling, integrate medical records, as well as and enhance communication with patients. Further, a new EHR will improve chronic disease management, provide data for research and population health improvements. Additionally, to the extent practical and appropriate, AI-based tools should be explored to further improve efficiency and care quality. Although no funding source is identified, DCAB strongly encourages identifying funding to prioritize these essential technology upgrades and SUNY has indicated other funding resources will be made available.

Improve Quality of Care

Most Brooklyn facilities have low quality scores relative to Manhattan facilities. SUNY Downstate's quality scores are comparable to other hospitals in the region, except for the Brooklyn hospitals that are part of larger systems in Manhattan that tend to have higher quality scores.

The Brooklyn community deserves the highest quality healthcare. DCAB urges all providers in the service area to improve health outcomes. As the Downstate transformation plan is implemented, a strong emphasis on improving quality measures must be a core component of the plan. Improvements in these quality metrics should serve as a key indicator for measuring the plan's success throughout implementation.

Effective Marketing and Fundraising

As the Downstate transformation plan is implemented, it will be important to develop a thoughtful and comprehensive marketing and communications strategy that effectively informs the public about the modernized facilities, new surgery center and specialty services, and overall positive changes taking place.

DCAB heard from the community and many other stakeholders the importance of SUNY Downstate to the central Brooklyn community. A concerted fundraising strategy and effort should be developed specifically to support the transformation plan.

As the federal landscape shifts, focused efforts to obtain grants and philanthropic support should be part of an overall plan to support SUNY Downstate, accompanied with targets, goals, and performance metrics.

Strengthen Collaboration

Downstate currently collaborates with several key hospital partners. Approximately two-thirds of 3rd year clerkships and residency placements take place at these partner affiliated hospitals. This current collaboration with Kings County, Maimonides, and others is essential in supporting SUNY Downstate's academic mission. While Downstate presently collaborates with other hospitals, some of those relationships appear strained and need to be strengthened.

There are opportunities to partner with existing federally qualified health centers (FQHCs) to enhance community healthcare and strengthen referral networks. Additional

opportunities include establishing and expanding health workforce collaborations, including stronger pipelines in the Brooklyn community with K-12 partners (e.g., Clara Barton High School for Health Professions) and community colleges.

DCAB recommends that SUNY Downstate explore strategic partnerships in Brooklyn and beyond. DCAB recommends efforts to better coordinate care and services in the region through new and/or enhanced affiliations that also improve health outcomes.

Community needs are vast, and a single, stand-alone hospital the size of Downstate does not have the capacity to fully address Brooklyn's extensive health needs.

Financial Feasibility

As part of working toward financial feasibility, Downstate needs dedicated and dynamic team focused on planning, achieving volume increases, shifting payer mix and payment rates, and reducing cost structure.

Current Hospital Reinvestment

Downstate offers an array of inpatient and outpatient services. It has general inpatient medical and surgical services, has a NICU and PICU, is one of two regional perinatal centers, has a primary stroke center designation which is the most basic stroke designation, and offers the only kidney transplant service in Brooklyn. Outpatient services include primary, specialty, diagnostic imaging, and laboratory services, Downstate also operates an emergency department.

There are six hospitals located within SUNY Downstate's primary service area (PSA) and secondary service area (SSA), with Kings County directly across the street and others relatively nearby.[1] Currently, about one-third of Brooklyn residents leave the borough for inpatient hospital care. This outmigration, primarily to Manhattan, has been longstanding. Within SUNY Downstate's primary service area, 60% of patients receive care elsewhere, either in Manhattan or other Brooklyn hospitals.

SUNY Downstate has consistently accounted for about 9% of inpatient volume in its primary service area. Nearly all Downstate admissions come through the emergency department and are not elective. SUNY Downstate's case mix index (CMI), a measure of the clinical complexity and acuity of the services, is approximately 1.5, which is comparable to other community hospitals in the region. Typically, teaching hospitals report higher CMIs than community hospitals, reflecting more specialized and intensive care. Downstate appears to lack a strong referral base or network.

[1] A primary service area (PSA) is the geographic region from where a healthcare provider draws most of its patients. SUNY Downstate's PSA is defined as zip codes 11203,11212, 11225, 11226, and 11236. A secondary service area (SSA) is the surrounding region that provides an additional percentage of patients. SUNY Downstate's SSA is defined as zip codes 11207,11208, 11210, 11213, 11233, and 11234.

DCAB recommends that Downstate maintain their current inpatient services and their emergency department and focus on higher acuity cases consistent with an academic medical center's mission and strengthen referral affiliations and partnerships.

Renovate Current Hospital – Address Mechanical, Electrical, Plumbing needs

The hospital is comprised of an 8-story wing and an attached 3 story section of building totaling 693,000 gross square feet. Historically, the building has received limited rehabilitative work and is deteriorating, requiring extensive renovation. Most of the mechanical, electrical, plumbing (MEP) systems and physical program spaces need major rehabilitation or replacement.

Most mechanical, electrical, plumbing (MEP) equipment distribution systems remain original to the building, including piping, fire protection, medical gas, and ductwork. This aging distribution infrastructure has led to repeated failures like flooding, temperature control issues, and emergency system shutdowns – all of which disrupt operations. To ensure safety and continued operations in the hospital, DCAB recommends that all identified MEP equipment and systems be replaced or rehabilitated as needed. This was estimated to cost approximately $250 million, of which about $125 million is estimated to have been allocated from prior capital funds for MEP projects that overlap with those identified for repair in the DCAB analysis.

Current Hospital Reinvestment – Rightsize and Renovate All Existing Patient Rooms

SUNY Downstate is certified for 342 beds, with approximately 286 currently operational. The average daily census at SUNY Downstate is about 165 patients, resulting in generally underutilized bed capacity, with occupancy levels varying by unit. The occupancy rate for certified beds is 48% and the occupancy rate for operational beds is 58%.

At Downstate, patient rooms, except for those in the transplant unit, are double occupancy and lack private showers. Current standards of care recommend single-occupancy rooms to support infection control, patient comfort and healing, and room for family and friends to visit.

Patients in Brooklyn deserve privacy, dignity, and patient rooms that meet current standards of care. Currently, SUNY Downstate has only 24 single-occupancy patient rooms with private showers, all located within the kidney transplant unit. An additional 11 labor and delivery rooms are in the process of being converted to private room with toilets and showers.

Over the next five years, DCAB recommends that all the remaining patient rooms on floors 2 through 8, including critical care units, be renovated and converted into single-occupancy rooms to enhance privacy, patient comfort and healing, while providing adequate space for families and friends to visit. This will result in a total of 192 beds.

Current Hospital Reinvestment – Create Additional New 33 Private Patient Rooms

In addition to converting existing double occupancy beds, capacity will be expanded by adding another 33 new private inpatient beds. These upgrades will better serve the community and help attract patients to Downstate. By converting existing double-occupancy medical-surgical rooms into single-occupancy rooms within the current infrastructure and adding 33 new private inpatient beds, Downstate's inpatient bed count will be approximately 225 beds.

Current Hospital Reinvestment – Nursing Stations and Inpatient Specialty Units

As the hospital floors are renovated to create private rooms with toilets and showers, the other areas of the floors will also be renovated including the nursing stations, central core support, and any existing dedicated inpatient specialty units. Further a new oncology dedicated specialty unit would be created and the prior cardiology unit restored and enhanced. This would be organized during the design and planning process. As full floors, or portions of floors, are renovated, sections could be dedicated to specialty areas, like how the kidney transplant unit is dedicated.

Current Hospital Reinvestment – Modernize and Expand the Emergency Department

At the public hearings, many community members voiced concerns regarding emergency department (ED) services, overcrowding, and wait times at both Downstate and Kings County hospitals. SUNY Downstate's emergency department is outdated and at times overcrowded, as treatment bays, rooms, and stretcher space are undersized. Despite these physical limitations, the timeliness of the care delivered at Downstate is better than most hospitals in the service area.

DCAB recommends that the current ED be modernized to align with contemporary space and design standards for emergency care, enhance operational efficiency, and provide a more welcoming environment for patients. This renovation may also allow more patients to be seen in a timely manner.

DCAB further recommends, as part of this effort, a 10% increase in ED capacity be further expanded to increase the number of treatment bays from 38 to 42 and adding 3 observation beds to support patient flow, reduce ED boarding, and help address community need.

Floor by Floor Renovation of the Current Hospital

Expanded Emergency Dept (Existing Hospital)			
45 Stations 550-650 SF/station	(existing) 38 stations	low 24,750 SF	high 29,250 SF
Outpatient (former Emergency Department space, Existing Hospital)			
11,300 SF	Exam Rooms	16	23
Patient Floor Rehab (Existing Hospital) Standard Single Rooms & Toilet Room w/ Sink & Shower			
Level 8 (w/Transplant MEP only)	(existing) 66 beds	reno 18 rooms/24 ETR	new total **44 beds**
Level 7 22,000 SF	(existing) 76 beds	reno 36 rooms	new total **42 beds**
Level 6 22,000 SF	(existing) 74 beds	reno 38 rooms	new total **42 beds**
Level 5 (partial) 17,550 SF	(existing) outpatient	reno 33 rooms	new total **33 beds**
Level 4 PEDS Beds - 9,710 SF	(existing) 22 beds	reno 12 rooms	new total **13 beds**
Level 4 PICU - 2,700 SF	(existing) 5 beds	**5 beds**	
Level 3 OBGYN Beds	under renovation		new total **11 beds**
Level 3 MICU - 4,450 SF	(existing) 10 beds	low **6 beds**	high **7 beds**
Level 3 NICU - expanded 8,450 SF	(existing) 29 stations	new total **13 beds**	
Level 2 CCU - 4,000 SF	(existing) 7 beds	low **5 beds**	high **6 beds**
Level 2 CT CCU - 5,610 SF	(existing) 9 beds	low **7 beds**	high **9 beds**
Specialty Care Unit Upgrades			
Resulting Single Bed Room Count		**225**	

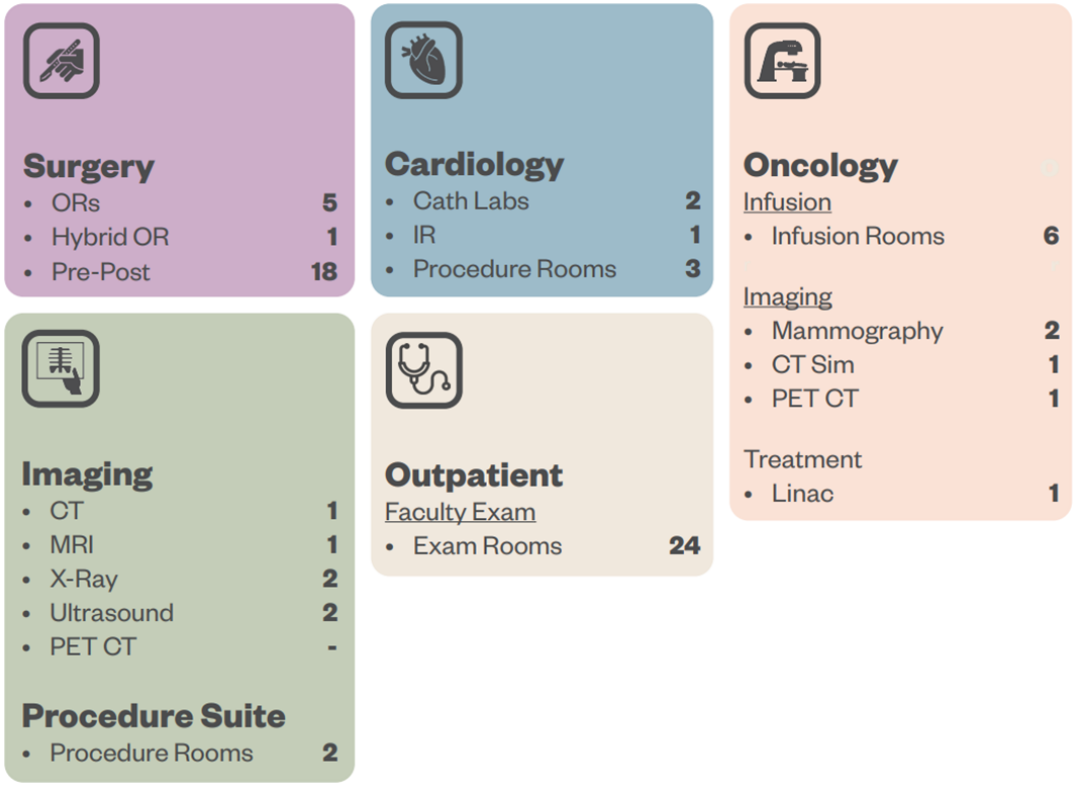
Build a New Hospital Annex Including Ambulatory Surgery Center ASC

New Hospital Annex with a state of the art ASC will focus on Oncology and Cardiology

Downstate currently offers a wide range of outpatient services, including primary and specialty care, diagnostic imaging, and laboratory services. Nationally, home and outpatient care settings are projected to be the fastest growing sites of care of the next decade - hospital outpatient department projected to grow 18% and ambulatory surgery centers grow 25% by 2032. DCAB recommends maintaining current outpatient services.

DCAB recommends building a new ambulatory surgery center (ASC) specializing in cardiology and oncology. This state-of-the-art, four-story facility will expand access to high-quality care for cancer and heart disease, the top two leading causes of death in Brooklyn, and would be built on the state-owned Lenox Road site currently occupied by the condemned parking garage across from the hospital.

The ASC will include a surgical suite with five operating rooms (ORs), one hybrid OR, and 18 pre-post beds. It also will feature a cardiology suite with catheterization labs and interventional radiology, and an oncology suite equipped with infusion rooms, advanced imaging, and a linear accelerator. Preliminary analysis indicates that there will be room for potentially 38 to 60 parking spaces at a surface lot next to the new ambulatory surgery center.



The Hospital Annex will be Built for Potential Expansion for Community Needs

The ASC will be designed to support potential future expansion, including the construction of additional floors after the initial facility is completed. Reinforced structural infrastructure will enable possible vertical additions of new floors or heavier equipment to be added, and MEP systems will be engineered to consider possible future needs. Floor layouts will also be planned to enable future horizontal expansion or bridge connections with minimal disruption to patient care spaces. This approach ensures that space can be expanded later to meet evolving community needs and strategic service priorities.

Timing for Infrastructure

The patient room renovation project to convert double-occupancy rooms to single-occupancy will be completed in place, with careful staging to minimize disruption to hospital activity. It is anticipated that the work will be divided into phases and completed over the next five years. Given current occupancy levels, the impact on operations is expected to be manageable without causing significant decline in financial performance.

Modernization and expansion of the ED will take place concurrently with the second phase of inpatient room renovations. The existing ED will remain fully operational during construction, as the new, modernized ED will be constructed on the opposite side of the hallway to avoid any disruption to emergency services.

The new ASC building will be constructed in parallel with hospital renovations, with the entire project expected to be completed in less than 10 years.

Capital Costs

The statute creating the DCAB resulted in a capital budget of $750 million. Additionally, the Governor directed SUNY to identify $350 million in other capital funding to support the multi-year DCAB recommendations. This figure includes an annual capital appropriation of $50 million over the next 7 year, bring the total budget to $1.1 billion.

	Capital Construction Midpoint Estimate	Soft Cost Estimate	Total Capital Cost Estimate
Hospital Renovation	$496 million		
Hospital Annex with ASC	$460 million		
Total	$956 million*		
Total Less Overlap MEP	$831 million	$287 million	$1,118 million

*$125 million in MEP-related costs was deducted from the cost estimate considering current hospital projects that overlap with the MEP systems DCAB analysis identified for repair

The above projects would need to meet federal and state requirements, including obtaining a certificate of need from the Department of Health.

Financial Feasibility

The hospital has revenue of approximately $500 million and has been running a deficit of approximately $80 million to $100 million without temporary state support. The size of the deficit depends on the type of accounting used (cash versus accrual) and the time period (state fiscal year, calendar year, academic fiscal year). Absent any changes, the deficit is projected to grow to $150 million annually over the next decade.

SUNY Downstate's payor mix is challenging with government payors like Medicaid and Medicare representing more than 80% of revenue. As a public hospital, SUNY Downstate receives generous disproportionate share payments (DSH), half of which are funded by the State, that largely help offset the financial losses associated with serving a high volume of Medicaid and uninsured patients.[2] Data provided by Downstate shows losses in Medicare and commercial payors. In the industry, it is unusual to lose money on commercial business.

SUNY Downstate's cost structure is significantly higher than other SUNY hospitals and peer academic medical centers of similar size. Labor salaries and benefits account for approximately 70% of overall costs. Due to its size, Downstate also lacks economies of scale.

No scenarios evaluated for DCAB, using reasonable change assumptions, resulted in a breakeven or positive margin. Financial and operating estimates for DCAB's recommendations depend largely on the extent to which Downstate can achieve inpatient and outpatient volume increases, grow the share of commercial payors, increase the rate paid by commercial insurers, reduce costs and become more efficient and enhance productivity.

Projection	Actual 2023	85% Occupancy, Currently Reported Economics	Market-Based Volume, Significantly Improved Economics	85% Occupancy, Very Optimistic Economics
Operating Income	($95 million)	($181 million)	($86 million)	($20 million)

85% Occupancy, Currently Reported Economics projection assumes volume is increased to reach 85% occupancy at the renovated hospital and the new ambulatory surgery center. To do this, SUNY Downstate's inpatient primary service area (PSA) market share would need to increase from 9% to 10%, and outpatient volume would

[2] Disproportionate share hospital (DSH) revenue is federal funding for hospitals that serve a high number of Medicaid and uninsured patients.

need to grow by approximately 60%. Based on these assumptions, and making no other changes in Downstate's cost structure or operations, projected net income is an operating loss of ($181 million).

The Market-Based Volume, Significantly Improved Economics model assumes growth of 4% in inpatient volume growth, 16% growth in outpatient volume growth, commercial payer mix that increases from 10% to 11%, achievement of commercial rates that approximate 125% of Medicare, an 8% reduction in overhead costs and a contribution margin of 30% that reflects minimal changes in current direct costs even as volume increases. Assuming these improvements are achieved, the projected total net operating loss could be approximately ($86 million). This analysis reflects ambitious but achievable assumptions and performance.

The 85% Occupancy, Very Optimistic Economics model assumes growth of 7% in inpatient volume growth, 56% growth in outpatient volume growth, commercial payer mix that increases from 10% to 22%, achievement of commercial rates that approximate 125% of Medicare, a 15% reduction in costs. This analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.

These figures assume that Downstate is not required to pay debt service on these capital investments.

See Attachment A: DCAB recommendations for a visual summary.

See Attachment B: DCAB recommendations (Infrastructure and Financial/Operating)

Other Options for Consideration if Additional Funding is Available

There are members of DCAB that believe additional resources should be allocated and prefer other options be considered to address SUNY Downstate and the community's needs if additional funding becomes available.

Brooklyn for Downstate New Hospital and New Ambulatory Surgery Center

Brooklyn for Downstate, a group representing local leaders, clergy, community-based organizations, and the hospital unions, spent significant time developing a proposal that would build a new hospital and a new ambulatory surgery center to address the healthcare needs of the community.

According to Brooklyn for Downstate, this proposal would align resources with demand by reducing beds from 342 to 250, improving efficiency and focusing on critical care services. It would modernize the infrastructure of the emergency department and add observation units and level 1 or level 2 trauma centers, create private labor and delivery and postpartum rooms, reduce NICU beds and expand outpatient care; rebuild heart surgery programs and maintain cardiac catheterization and stroke centers, establish an inpatient oncology service to provide cancer treatments, and reinvigorate kidney transplant programs. It would also establish urgent care, ambulatory surgery centers, and create outpatient preventive care centers focused on diabetes, cardiovascular health, maternal care, and stroke prevention.

The DCAB met with Brooklyn for Downstate twice to better understand the proposal and its costs. Brooklyn for Downstate presented its own cost estimates, totaling $2.5 billion. DCAB's consultants also projected costs, using a methodology consistent with how the other scenarios resulting in a total cost estimate of $3.75 billion (see table below). Variations in cost estimates reflect differences in modeling assumptions, especially soft costs and construction timing.

The estimated capital costs of the plan significantly exceed DCAB's budget.

	Capital Construction Midpoint* Estimate	Soft Cost Estimate	Total Capital Cost Estimate
New Hospital Construction	$2.1 billion	$670 million	$2.77 billion
New Ambulatory Surgery Center	$709 million	$235 million	$944 million
Total	$2.8 billion	$905 million	$3.75 billion

For a detailed comparison of these assumption differences, see Appendix 4-A.

The operating deficit of the proposal is significantly worse than the current deficit.

Projection	Actual 2023	85% Occupancy, Currently Reported Economics	Market-Based Volume, Significantly Improved Economics	85% Occupancy, Very Optimistic Economics
Operating Income	($95 million)	($365 million)	($173 million)	($155 million)

The Brooklyn for Downstate group did not provide its own financial modeling estimates.

Much more detail on this proposal is available in the Scenarios Evaluated section of this report and associated appendices.

Large State of the Art Diagnostic & Treatment Center with a New 200 bed Patient Tower

This option would involve building a new, modern diagnostic & treatment center (D & TC) focused on outpatient specialty care and advanced ambulatory surgery. It would include operating rooms, imaging, and dedicated space for cardiology, oncology, women's health, orthopedics, endocrinology, and more – consolidating many needed services in one place. A new 200-bed inpatient tower would be built next to the center to offer comfortable, private rooms and modern facilities for patients. The existing hospital would undergo limited renovation, with the existing ED be renovated and downsized to reflect the shift in focus to specialized, elective procedures. The new D&TC, inpatient bed tower, and current hospital would all be connected through a bridge system.

This proposal would align services with broader trends in healthcare delivery, which are trending towards more care being delivered in the outpatient setting.

The capital costs of the plan significantly exceed DCAB's budget.

	Capital Construction Midpoint* Estimate	Soft Cost Estimate	Total Capital Cost Estimate
New Diagnostic & Treatment Center	$1.09 billion	$360 million	$1.45 billion
New Inpatient Bed Tower	$984 million	$325 million	$1.3 billion
Existing Hospital Renovation	$333 million	$110 million	$443 million
Total	$2.4 billion	$795 million	$3.2 billion

The operating deficit of the proposal is significantly worse than the current deficit.

Projection	Actual 2023	85% Occupancy, Currently Reported Economics	Market-Based Volume, Significantly Improved Economics	85% Occupancy, Very Optimistic Economics
Operating Income	($95 million)	($353 million)	($117 million)	($143 million)

Much more detail on this proposal is available in the Scenarios Evaluated section of this report and associated appendices.

Additional Primary, Preventive and Public Health Investment

Some DCAB members believe additional investment for primary care, preventive services, and public health are needed for Brooklyn to improve health outcomes. It is believed that by building a stronger public health infrastructure and investing resources towards community-based care, rather than expanding hospital inpatient bed capacity, may offer greater long-term benefits for population health in the region.

This approach aligns with the ongoing need to address longstanding health disparities in Brooklyn, where communities experience some of the city's highest rates of chronic conditions such as diabetes, hypertension, and asthma. Cancer and heart disease are the two leading causes of death in Brooklyn, and often are more treatable when identified early through regular preventative screenings. Strengthening primary and preventative care access could improve outcomes for residents facing these high-risk conditions.

Further, Brooklyn has one of the lowest ratios of general practitioners per 100,000 population among the five boroughs, limiting timely access to routing care, early diagnosis, and chronic disease management. As a result, many individuals turn to emergency departments for conditions that could be more effectively and affordably managed in outpatient settings. This misuse and overuse of ED services strains hospital resources and contributes to poorer patient experiences and outcomes. Strengthening primary, preventative, and public health infrastructure across the borough could reduce unnecessary emergency department visits, support earlier intervention, and lead to healthier outcomes for the community.

Downstate Community Advisory Board (DCAB)

Background

Last year in the 2025 Enacted Budget, Governor Hochul and the state legislature created the Downstate Community Advisory Board for the modernization and revitalization of SUNY Downstate. DCAB is charged with recommending a reasonable, scalable, and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate. The recommendations may not exceed more than the available $750 million capital investment. See Appendix 1 for the DCAB statute found in section 996 of the Executive Law.

The Downstate Community Advisory Board was originally charged to submit written recommendations to the Governor and Legislature by April 1, 2025. Given the desire for public engagement, the report deadline was extended to on or before June 1, 2025.

Membership

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

On November 25, 2024, the Governor announced eight members (see Appendix 1 for press release) and the ninth DCAB member was appointed on January 22, 2025. Individuals that have served on the DCAB are:

- **Dr. Enitza George**, SUNY Downstate Chair of the Department of Family and Community Medicine and Chief Population Health Officer
- **Dr. Lesly Kernisant**, Brooklyn Plaza Medical Center (retired)
- **Dr. John B. King, Jr.**, SUNY Chancellor
- **Dr. Fred Kowal**, United University of Professions (UUP) President
- **Dr. James V. McDonald**, NYS Department of Health (DOH) Commissioner
- **Dr. Donald Moore**, Primary care physician, Owner and CEO of Dr. Moore and Associates
- **Claire Patterson**, Deputy Executive Director & Chief Operations Officer NYC H+H/Community Care (retired)
- **Andrew Rein**, Citizens Budget Commission President
- **Pastor Louis Hilton Straker Jr.**, 67th Precinct Clergy Council

The DCAB met frequently, mostly in person, to review data and deliberate on options and recommendations. There have been four public hearings to solicit recommendations from the community. In total, each DCAB member spent an estimated 100 hours in briefings, meetings, public hearings and preparation work. DCAB members are dedicated and passionate and have been extensively engaged throughout the entire process.

The DCAB generously gave their time to thoroughly listen to the community, deepen their understanding of SUNY Downstate, and provide guidance and direction to the consultants.

Technical Assistance

Given the level of detailed analysis and need for specific healthcare industry expertise, a team of consultants were engaged to provide support to the work of DCAB including:

- ADENA Consulting Group, LLC. ADENA Consulting Group, LLC, led by Oma Holloway, has coordinated and facilitated DCAB meetings and the four public hearings.

- QPK Design a multi-disciplinary architectural/engineering firm, provided architectural assessments of existing facilities and developed comparative scenario-based cost estimates, and assessed physical feasibility of concepts.

- Ramboll, an engineering firm, performed a detailed mechanical infrastructure assessment of the current hospital, identifying deficiencies and long-term viability concerns within the building systems.

- Ewing Cole, a multi-disciplinary architectural/engineering firm with expertise in healthcare design, contributed programming and design studies and construction phasing strategies that informed the development of practical, implementable facility options.

- Kaufman Hall, a financial and strategic consulting firm, led the work on the current market assessment and financial modeling.

- Deloitte, a financial and strategic consulting firm, assessed the reasonableness of the financial modeling and identified options to reduce the deficit.

Other

DCAB members received no compensation for their service.

See Appendix 1: DCAB Charge and Membership for additional information.

Outreach

Community input was a critical and foundational component of the Downstate Community Advisory Board process. The advisory board was required to hold no less than three public hearings to solicit input and recommendations from any interested party, including from healthcare experts, county health departments, community-based organizations, state and regional healthcare industry associations, labor unions, experts in hospital operations, and other interested parties.

DCAB Public Hearings

Given the importance of community engagement to the DCAB, an additional public hearing was held beyond the minimum, a public facing website was created that provided information on the DCAB charge, membership, public hearing announcements, and slides used or made available at the hearings. The website can be found at www.downstateadvisoryboard.org.

In addition to posting hearing announcements on the website, hearing announcements were sent to Community Boards 9, 17, 3 and 14 (primary and secondary zip codes); Brooklyn Delegations of the City Council, Assembly and Senate; elected represented in the US Senate and House; Office of the Borough President. Brooklyn for Downstate was instrumental in outreach via social media and on the ground outreach to the community.

- Hearing 1 was held on January 22, 2025, at SUNY Downstate from 6pm to 9pm. Overall attendance was approximately 375 people. DCAB heard from 56 individuals and 12 elected officials. There were 50 written submissions.

- Hearing 2 was held on February 27, 2025, at Medgar Evers College from 6pm to 9pm. Overall attendance was approximately 150 people. DCAB heard from 25 individuals and 11 elected officials. There were 8 written submissions.

- Hearing 3 was held on March 13, 2025, at SUNY Downstate from 6pm to 8:30pm. Overall attendance was approximately 188 people. DCAB heard from 22 individuals and 3 elected officials. There were 6 written submissions.

- Hearing 4 was held on April 28, 2025, at Medgar Evers College from 6pm to 8:30pm. Overall attendance was approximately 163 people. DCAB heard from 26 individuals and 5 representatives of elected officials. There were 8 written submissions.

Public Hearing Themes

Across all four public hearings, the importance of SUNY Downstate to the Central Brooklyn community emerged as the most prominent and consistently expressed theme. Community members emphasized the hospital's role as a critical access point for healthcare, a center for education, and a longstanding anchor institution in the community – with many citing personal experiences as SUNY Downstate patients, students, or employees. Additional common themes included the need for ongoing and further investment in SUNY Downstate, along with the importance of transparency in the DCAB process and ongoing community engagement. Many participants also stressed the importance of maintaining inpatient and outpatient services, modernizing infrastructure, and investing in a hospital model that supports both health equity and academic excellence.

Public Hearing 1

- The first public hearing included detailed discussions about clinical services. Speakers identified several specific areas of care, including cardiology, oncology, hematology, pulmonology, orthopedics, HIV treatment, urology, and sickle cell care.

- Participants also raised concerns about existing infrastructure, such as the electronic medical record system, infection control, and the need for private rooms.

- Multiple testimonies referred to the high rates of cancer in the borough as well as the Black maternal health crisis.

- The hospital's role in education and research was also noted, with several speakers emphasizing the hospital's role in medical training.

- Many speakers expressed opposition to any closure plans of SUNY Downstate (despite none being under consideration).

- There were also calls for extended planning time for the DCAB beyond the April 1, 2025, deadline.

Public Hearing 2

- The second public hearing focused on the relationship between Downstate's academic mission and its hospital operations.

- Medical students and faculty testified to the need for clinical services that support education and research, with particular emphasis on imaging, transplant services, cardiology, radiation oncology, and lab infrastructure.

- Chronic disease management and health disparities were also recurring topics, including diabetes, kidney disease, and colorectal cancer.

- The Black midwifery model, autism treatment, and pediatric primary care were other service areas discussed.

- Multiple speakers discussed expanding workforce development, like cultural competency training for SUNY Downstate employees, and support for public health initiatives like employing more community health workers, doulas, and social service providers.

- Concerns about the number of hospital beds, reimbursement rates, and availability of equipment were raised alongside suggestions for better parking and shorter waiting times to improve healthcare access at SUNY Downstate.

- Multiple capital projects ideas were discussed, including new construction, a bridge to Kings County hospital, and modernization of current infrastructure.

- Several participants called for an extension of the April 1, 2025, DCAB report deadline.

Public Hearing 3

- At the third public hearing, DCAB consultants announced that the deadline for its final report had been extended from April 1 to June 1, 2025, and provided an overview of its work to date with attendees. This presentation included a reminder of DCAB's charge, an update on outreach efforts, a summary of public feedback heard so far, a high-level assessment of SUNY Downstate's strengths and challenges, and a spectrum of cost estimates for various hypothetical capital models.

- While many participants expressed appreciation for the information presented, several continued to call for greater transparency in the DCAB process, particularly around the data and planning scenarios under consideration.

- Participants also reiterated the importance of maintaining both inpatient and outpatient services, as well as a physical connection between the hospital and academic campus.

- Specific areas of care highlighted included Black maternal health, cancer treatment, orthopedical and rehabilitation services, addiction services, and gender affirming care.

- Additional topics included the need for cultural competency training for SUNY Downstate staff, improved hospital maintenance, reduction of health disparities, and better transportation and parking access to the facility.

Public Hearing 4

- At the fourth public hearing, DCAB consultants provided an overview of its work to date with attendees. This presentation included information provided in hearing 3 plus a review of some of the scenarios DCAB was evaluating.

- Participants continued to voice strong support for maintaining SUNY Downstate's presence in Central Brooklyn, with heightened emphasis on preserving inpatient services as essential to both community health and the institution's academic mission.

- Several speakers pointed to the hospital's aging infrastructure and stressed the need for substantial capital investment – framing the $750 million allocation is a starting point, with requests reaching $1 billion and $2 billion.

- One participant proposed the creation of a unified healthcare system that would consolidate existing Brooklyn hospitals under a single, integrated structure, as well as strengthening in-house maintenance operations to reduce the number of projects completed by external contractors.

- Many speakers expressed opposition to any closure plans of SUNY Downstate (despite none being under consideration).

Additional Outreach

To further DCAB's understanding of the vision and operations of the Downstate academic campus, the hospital, and the intersections, DCAB met with leadership at SUNY Downstate:

- Dr. Wayne Riley, SUNY Downstate president
- Dr. Pat Winston, interim CEO of the hospital

DCAB has met with additional stakeholders throughout the process. Some stakeholders developed specific needs assessments and proposals. DCAB meetings included:

- Two meetings with Brooklyn for Downstate early and later in the DCAB process
- SUNY Downstate Chairs

DCAB also thought it was important to learn more first-hand about the market and relationship dynamics and opportunities. These meetings included leadership at the following facilities/systems:

- Health & Hospitals and Kings County Medical center
- Maimonides Medical Center
- One Brooklyn Health

Other Information

See Appendix 2 for hearing announcements and slides made publicly available.

Detailed Findings

Consistent with the statute, DCAB reviewed and examined a variety of options to strengthen SUNY Downstate and promote longer term viability for its dual education and healthcare mission. In conducting its study, the advisory board considered the following factors:

Community healthcare needs, outcomes, and health disparities

- Brooklyn faces high rates of chronic conditions, limited and expensive healthcare access and challenging socioeconomic factors. The prevalence of obesity, diabetes, and hypertension for residents in Downstate's primary service area (PSA) and secondary service area (SSA) are higher than the rates in Kings County and New York City.

- Brooklyn has 352 general practitioners per 100,000 population. Only the Bronx has a lower rate of general practitioners at 226 per 100,000 population compared with the other boroughs, influencing availability of primary and preventive care services.

- The Vizient vulnerability index identifies social needs and obstacles to care that may influence a person's overall health and it shows PSA and SSA residents are more vulnerable than many areas of Brooklyn.

- In Brooklyn, heart disease and cancer are two leading causes of death followed by accidents, stroke, flu and pneumonia, diabetes, and chronic lower respiratory disease.

- The Community Health Needs Assessment 2022 prepared by the NYC Health & Hospitals was also found to be helpful, especially the information provided for Kings County hospitals which is across the street and serves the same community[3]. This report identified specific areas of concern including inequities related to pregnancy, asthma, hypertension, diabetes, aging and frailty, substance use, mental health, and violence

- The Report on the New York State Department of Health's Study of Healthcare System Inequities and Perinatal Access in Brooklyn, New York was also reviewed. The report found that Brooklyn faces a number of common and unique challenges in ensuring high-quality, accessible, and affordable healthcare. The report highlighted that there is significant and increasing outmigration from Brooklyn to Manhattan and elsewhere for care, and that while the level of quality

[3] community-health-needs-asssessment-2022.pdf

differs across providers in the region, Brooklyn's higher volume facilities have shown lower rates of avoidable complications.[4]

- The DCAB also reviewed the Brooklyn for Downstate data needs analysis and recommendations for the future of SUNY Downstate which reinforced and highlighted the community health needs of Downstate's neighborhood.[5]

- See Appendix 3-A for additional information.

Overall healthcare service delivery trends and models

- Nationally, the healthcare ecosystem experienced crisis during the pandemic, it has taken some time to stabilize and its beginning to normalize. New York hospitals experienced losses that were greater and as margins have rebounded nationally, NYS margins are typically lower. The gap between higher and lower performing organizations persists and is widening. Despite an environment that has generally improved since the pandemic, there are significant pressures related to clinical labor costs, medical inflation, payer mix and changing delivery settings.

- More and more, the industry is moving away from a facility-centric model. Health systems are increasingly being asked to meet patients along the care continuum.

- Nationally, home and outpatient care settings are projected to be the fastest growing sites of care of the next decade - hospital outpatient department projected to grow 18% and ambulatory surgery centers grow 25% by 2032. This compares to an annual rate of growth of 2% for inpatient care and a decline of 2% for emergency department over the next 10 years.

- See Appendix 3-B for additional information.

Existing inpatient and outpatient service offerings and health outcomes

- Downstate's PSA and SSA 11 zip codes and within that service area there are five other hospitals. SUNY's PSA is home to a slightly declining overall population, with growth in the 65 and older cohort. While there is gentrification occurring throughout Brooklyn over the next 5 years the population is not projected to grow.

[4] https://www.health.ny.gov/press/reports/docs/brooklyn_perinatal_access_report.pdf
[5] Data Analysis & Recommendations for the Future of SUNY Downstate

- Downstate offers an array of inpatient and outpatient services. It has general inpatient medical and surgical services, has a NICU and PICU, is one of two regional perinatal centers, has a primary stroke center designation which is the most basic, and offers the only kidney transplant service in Brooklyn. Downstate operates an emergency department and provides outpatient services.

- The Department of Health has certified Downstate to operate a maximum of 342 licensed beds. Most rooms in the hospital are double occupancy and are not private with toilets and showers. There are approximately 286 beds that are physically operational. Occupied beds are the number of beds occupied by patients. Staffed beds are the number of beds that can operate given the available staffing. Typically, hospitals staff to general occupancy levels with some cushion for volume peaks and lows.

- In AFY23-24 the average daily census (occupancy) was 165 beds. The occupancy rate for certified beds is 48% and the occupancy rate for operational beds is 58%. In the most recent non-pandemic years, the highest monthly average daily census was 203 and the lowest monthly average daily census was 116.

- During the pandemic years (AFY2020 and AFY2021) the lowest occupancy during Covid was 84. Downstate served as a Covid-only hospital for approximately 10 weeks – from March 28, 2020, through June 8, 2020.

- Occupancy rates differ by nursing units, for example, the calendar year 2023 operational bed occupancy rate was 49% overall but ranged from a high of 63% in medical/surgery to a low of 27% and 11% for NICU and pediatrics respectively.

- See Appendix 3-C for additional information.

Capacity and availability of inpatient and outpatient services in the broader primary and secondary service areas

- Of all the hospitals in Brooklyn, Maimonides Medical Center, NYP Brooklyn Methodist and NYU Langone Brooklyn are the largest in terms of hospital discharges (between about 23,000 and 27,000). Within the Downstate PSA and SSA, the hospitals are smaller with Kings County being the largest in beds with almost 16,000 discharges and Downstate with almost 7,000.

- In calendar year 2023, the case mix index (CMI), which is a measure of acuity of services, ranges from 1.3 (Interfaith) to 1.7 (Maimonides) for all hospitals in Brooklyn. The CMI for Downstate is 1.5. Typically, CMIs are highest for academic medical centers are higher than community hospitals.

- Maimonides, NYP Brooklyn, and NYU Langone each deliver between 3,500 and 5,100 babies annually. Within the PSA and SSA SUNY Downstate and Brookdale have the fewest deliveries at about 500 annually.

- With respect to designations, Downstate is a level III NICU, is a primary stroke center and is an AIDS center. Within the PSA and SSA, Kings County, across the street, is a Level I trauma center, level III NICU, thrombectomy capable and is an AIDS center. For the remaining hospitals in the PSA and SSA, Brookdale is a level II trauma center, and a level III NICU that is thrombectomy capable and has an AIDS Center; and Maimonides Midwood and Mount Sinai Brooklyn are primary stroke centers without AIDS centers.

- There is programmatic fragmentation for some services across Brooklyn hospitals in near and around Downstate. For example, Downstate, Maimonides, Kings County and One Brooklyn Health all have pediatric ICU beds, Neonatal ICU beds and varying births per day. Maimonides has approximately 14 births per day, Kings County at 4 per day and Downstate and OBH at less than 2 per day.

- Post pandemic the overall PSA inpatient market size declined more than 11%. Between 2022 and 2023, the inpatient market size stabilized at around 42,000 and SUNY Downstate's market share has remained at 9% pre and post pandemic.

- When market share is examined across the PSA, SUNY Downstate market share is generally consistent across service lines with a low of 7% in OB delivery and high of 12% in pulmonary. Generally, NYC Health + Hospitals lead the psychiatric market and NYP is strong in OB and neonatology.

- Even as the emergency department market in the PSA has expanded and contracted over the past several years, Downstate market share has stayed consistent at about 12%. Pre-pandemic there were about 195,000 visits and post pandemic market stabilized at around 180,000 annually. Over 90% of Downstate's patients are reached via outpatient care settings, predominantly the clinic and emergency department.

- Delivery volume from the PSA has declined across the market and Downstate specifically. Post pandemic the overall number of deliveries originating in the PSA declined more than 12%. Further Downstate's market share declined from 12% in 2019 to 7% in 2023.

- Across service lines, NYC H+H Kings County operates at a significantly larger scale than Downstate. The exception being transplants, which is not a service Kings County hospital provides.

- Approximately 60% of patients in the SUNY Downstate PSA out migrate for care, primarily to Manhattan (17%) or other Brooklyn hospitals (36%). The top three hospitals outside the PSA that residents are out-migrating to are NYP, Mount Sinai, and Maimonides. The highest rates of outmigration by service line are OB delivery and neonate. Commercial patients seek inpatient care in Manhattan at almost twice the rate (27%) of Governmental patients (14-15%).

- Like many areas examined, the outpatient surgery market in the PSA is also fragmented across many health systems and independent providers. However, this is an expected area of future growth.

- See Appendix 3-D for additional information.

Historic and projected financials for the hospital and the campus

- SUNY Downstate's operating income margin was -13% the year prior to the pandemic and worsened to during the pandemic and post pandemic remains negative 25%, before adjusting for one time revenue and special supports. Similarly, net income was about negative 5% the year prior to the pandemic and remains almost 9% negative post pandemic, before any adjustments. The forecast for SFY2024-25 was a loss of approximately $100 million without special state support.

- Without government financial support, SUNY Downstates net income margins decrease sharply. Net income margin has been on a broadly downward trajectory and worsens significantly when DSH payments and state support like VAPAP and appropriations are excluded.[6] When projecting into the future, without state support, SUNY Downstate's annual gap to a breakeven net income margin of $150 million. For 2024 and 2025, the State committed up to $100 million annually to address this gap while a longer term plan is developed.

- SUNY Downstate's PSA and SSA have a high Medicaid and low commercial population mix compared to the New York average. For example, government payers (Medicaid and Medicare) make up approximately 73% of payor mix in the PSA and SSA. This compares to an estimated 59% in New York State and 71% in Kings County. The contrast is especially sharp for the commercial share which in NYS is 36%, and in Kings County and Downstate's PSA and SSA approximately 22% - 23%.

- SUNY Downstate's payor mix is comparable to other Brooklyn hospitals but has a high reliance on government payors. For example, the commercial

[6] Vital Access Provider Assurance Program (VAPAP) revenue: state funding to provide additional support to financially distressed hospitals with critical cash flow needs

payor mix for Downstate is only 12% compared to 23% at Maimonides and 19% at Brooklyn Hospital Center. Additionally, larger health systems with presences in Brooklyn serve a larger commercial population, supporting their financial performance.

- SUNY Downstate's income statement demonstrates a high reliance on government funding with a labor heavy expense base. Net patient service revenue accounts for just over half of all total revenue, while government funding accounts for 37% across DSH, VAPAP, and state appropriations. Salaries and benefits are the greatest portion of Downstate's expenses, approximately 70%, and its share of total expenses has grown over the past five years.

- Additionally Downstate faces challenges associated with aging facilities along with low capital spending. Although capital spending has increased the past three years, Downstate's capital spending ratio has decreased over the past five years with depreciation outpacing capital spending. Historically, SUNY hospitals have had to pay debt service on capital spending.

- SUNY Downstate's financial performance lags behind the PSA and SSA and broader market competitors. Compared to Brooklyn hospitals with similar patient population, Downstate has lower profitability. Larger regional systems have healthier financial profiles than Downstate and similar Brooklyn facilities.

- The University/campus finances over the last nine years show five years of annual surpluses and three years of losses and one year that was essentially breakeven. The loss in AFY19-20 was significant, approximately 33%, likely related to Covid. The following year experienced a surplus in the other direction of a similar magnitude, potentially due to covid related relief funding. There were also significant losses in AFY21-22 and 22-23 totaling approximately $43 million, which are largely explained by the campus loan to the hospital in those years totally about $45 million. In the last completed AFY, there was a surplus of almost $9 million representing about 7% of revenue.

- Due to the more intensive nature of the type of programs University of Health Sciences offers, they have a lower student to FTE ratio. That ratio has varied between 1.1 to 1.3 over the last 12 years. For the most recent academic year, there were 1,461 campus FTEs and 1,954 students.

- See Appendix 3-E for additional information.

Efficiency of operations and quality of healthcare services benchmarking

- SUNY Downstate's cost structure is high compared to SUNY peers and academic medical centers of similar size.

- When SUNY Downstate's operational performance is compared to SUNY peers, who are 4 times its size, revenue per FTE is lower and expense at about same level as SUNY Stony Brook but less than SUNY Upstate. When revenue per FTE is compared with other academic center the size of Downstate, revenue per FTE is about 1/3 lower.

- SUNY Downstate has both higher revenue and expenses than similar-sized academic medical centers, but expense multiples are higher than revenue after adjusting for case mix index (CMI) weights and occupied beds. Total expense per CMI-weighted adjusted discharge is almost 3 times higher than comparable academic centers with less than $1 billion in revenue. This is true of not just overall expense but the labor expense as well. After accounting for DSH, the net operating revenue per CMI-weighted adjusted discharge is about 2 times higher than the median.

- When a similar analysis is applied to the other SUNY Hospitals, Downstate has total FTEs per CMI weighted adjusted occupied bed of 6.5, significantly higher than its sister hospitals at 4.9 and 4.0, Stony Brook and Upstate respectively.

- The majority of facilitates operating in Brooklyn have low quality and patient satisfaction scores relative to Manhattan facilities. SUNY Downstate has a leapfrog hospital safety grade of C, which is like other hospitals in Brooklyn except for the hospitals that are part of larger systems in Manhattan the at scores of A and B.

- Medicare has a star rating that ranks hospitals from 1 to 5 stars with 1 being the worst and 5 being the best. Downstate, similar to nearby hospitals, received a 1 star rating. H + H's Woodhull and Bellevue were ranked 2 stars, and the large health systems in Manhattan with Brooklyn presence had 3 to 5 stars. HCAHPS, another CMS ranking related to patient satisfaction, ranks most hospitals like Downstate and nearby hospitals at 2 stars. The large Manhattan health systems that have a Brooklyn presence again rank higher at mostly 3 stars.

- According to DOH clinical quality reporting, Downstate's scores on specific composites for patient safety and mortality is about average for Brooklyn hospitals, as well as for hospital-wide 30-day unplanned readmissions. On patient satisfaction in general, Downstate's score on whether patients would recommend the hospital to friends and family is the highest in Brooklyn, while it was average for NYS.

- Despite an older design, SUNY Downstate generally performs well on emergency department timeliness compared to regional peers. In terms of median time from ED arrival to ED departure for patients that are not admitted, SUNY Downstate compares favorably to Kings County hospital and many of the surrounding Brooklyn hospitals. Downstate has a small percentage, about 1% of patients that leave the ED without being seen. The time it takes from when a decision to admit a patient to when they are admitted to inpatient status takes somewhat longer than most peers, other than Kings County hospital which has a significantly higher wait time than Downstate.

- See Appendix 3-F for additional information.

Current state of building infrastructure and capital needs

- SUNY Downstate hospital was constructed in 1966. It is comprised of an 8-story wing and an attached 3 story section of the building totaling almost 700,000 gross square feet. Historically, the building has received limited rehabilitative work and is deteriorating.

- Major equipment (e.g. cooling towers, boiler room, emergency generators) in mechanical equipment rooms have been upgraded over the past decade. However, most equipment distribution systems remain original to the building – including piping, fire protection, medical gas, and ductwork. Aging distribution infrastructure has led to repeated emergency repair, flooding, and temperature control failures. For example, there was a recent tank explosion in the basement. Upgrading distribution systems is disruptive to staff and patients and would need to be phased. The estimated cost for needed mechanical, electrical, and plumbing (MEP) systems is approximately $250 million.

- The full assessment of the current hospital building included detailed external and floor by floor assessments of architectural, physical, and functional components of the hospital, as well as the level of renovation needed to bring the infrastructure to current standards and improve the overall environment of care. The assessment found that many clinical areas are not up to modern standard, citing double occupancy inpatient rooms, inaccessible toilet and/or bathing facilities, undersized ED treatment bays and rooms, limited visibility from nurse stations to patient cubicles, among other observations.

- Renovation was recommended at major, minor, and finish levels and would bring the facility to current standards regarding physical spacing and private rooms. If the current hospital were to be fully optimized, it would result in approximately 192 private patient rooms with bathrooms and showers as well as larger emergency department spacing. To fully renovate the current

hospital, it would cost an estimated $838 million before soft costs are included. When soft costs are added, approximately 33% for furniture, fixtures, and equipment and design and development, and other costs the projected cost is about $1.115 billion.

- See Appendix 3-G for additional information.

Training needs for students and employment outcomes

- Downstate Health Sciences University is comprised of five schools and colleges including the College of Medicine, College of Nursing, School of Health Professions, School of Public Health, and School of Graduate studies. Almost 2,000 students are enrolled in these high quality educational programs.

- The University is home to a diverse student population. Specifically for the medical school, by enrollment and graduates, Downstate is the largest medical school in NYC and in the top 3 for NYS. Downstate had the most underrepresented in medicine medical school graduates in NYS in the class of 2023.

- Many physicians trained at Downstate remain in NYS (74%) or NYC (51%) or at Downstate hospital (16%). The medical school graduates support primary care, with over 30% of graduates matching to internal medicine, family medicine, or pediatrics.

- Physicians must receive clinical training and that includes 3rd year clerkships, residencies, and increasingly earlier exposure to patients in health care settings. Approximately one-third of these placements are at Downstate hospital and the remaining two-thirds are at partner affiliated hospitals. For clerkships, Maimonides and Kings County hospital are the most significant partners. For residencies, Kings County hospital is the largest comprising 44% of the remaining 66% of non-Downstate residency placements.

- See Appendix 3-H for additional information.

Other considerations

- Downstate is on an outdated and antiquated electronic health record (EHR) system. Further, the outpatient/ambulatory care practices are on different systems than the hospital resulting in potential loss of referrals, issues with billing, and making it more challenging to easily view patients' full medical history.

- See Appendix 3-I for additional information.

Scenario Evaluation

Hypothetical Modeling

The current state capital assessment, as required by statute, outlined the investment required to address core system issues within the current hospital building, as well as the costs to modernize the facility to meet current regulatory standards and improve its overall condition. To further understand possible capital cost ranges for potential final scenarios, DCAB studied hypothetical capital models. These models included the cost of building a new ambulatory surgery center, constructing a new 193-250-bed hospital, and exploring bridge options connecting SUNY Downstate to Kings County Hospital. These hypothetical models were designed to inform DCAB discussions about final scenarios to be modeled for recommendation consideration and selection.

Hypothetical Ambulatory Surgery Center. The hypothetical ambulatory surgery center (ASC) was conceptualized as a new 4-story building totaling approximately 233,000 building gross square feet (BGSF). The ASC program was based on a previous ASC concept considered by SUNY Downstate in 2022. The hypothetical ASC program included an urgent care center, a surgical suite with nine operating rooms (ORs) and one hybrid OR, a cardiology suite with catheterization labs and electrophysiology, and a rehabilitation gym. Additional outpatient centers within the ASC included a women's health institute, a cancer institute with infusion and radiation oncology, an orthopedics and sports medicine institute, a wound care clinic, and an endocrine and metabolic clinic. Additional program components comprised of general imaging, procedure space, a sterile processing unit, and a main lobby with cafe.

- The architectural cost estimate of the hypothetical ASC ranged $680 million - $785 million in direct capital costs. Soft costs and furniture, fixtures, and equipment (FFE) were not considered in hypothetical models.

Hypothetical New Hospital, 193 beds and 250 beds. The hypothetical new hospital was modeled in two versions: a 193-bed facility conceptualized as a 13-story building totaling approximately 735,000 BGSF, and a 250-bed facility conceptualized as a 14-story building totaling approximately 784,000 BGSF. The hypothetical new hospital program replicated SUNY Downstate's current program, including all currently provided inpatient and outpatient services.

- The architectural cost estimate of the hypothetical 193-bed hospital ranged $2.2 billion - $2.6 billion in direct capital costs, while the 250-bed version ranged $2.3 billion - $2.7 billion. Soft costs and furniture, fixtures, and equipment (FFE) were not considered in hypothetical models.

Hypothetical Bridge to Kings County. The hypothetical bridge was conceptualized as a connection between level 5 of SUNY Downstate's patient tower and Kings County's patient tower, spanning 450 feet over Clarkson Avenue. An additional approach to a fictional bridge was modeled connecting SUNY Downstate's obstetrical care unit on level 3 – the section closest to Kings County – with Kings County's patient tower, which spanned 256 feet over Clarkson Avenue.

- The architectural cost estimate of the 450-foot bridge ranged $47 million - $52 million in direct capital costs, while the 256-foot version ranged $27 million - $30 million. Soft costs and furniture, fixtures, and equipment (FFE) were not considered in hypothetical models.
- Cost estimates generated from the hypothetical model exercises, along with estimates from the current state capital assessment to address core system issues and modernize the current hospital building, were presented at DCAB Public Hearing #3 in April 2025, see Appendix 2.

Initial Interpretation of Brooklyn for Downstate. The initial interpretation of the Brooklyn for Downstate plan was based on renderings released by the group in February 2025. This was conceptualized as a new hospital tower constructed atop the existing three-story podium of the current hospital, resulting in a 15 story building totaling approximately 830,000 building gross square feet (BGSF). The new hospital program was based on a previously released Brooklyn for Downstate public report "*Data Analysis & Recommendations for the Future of SUNY Downstate*" in December 2024.The initial interpretation of the Brooklyn for Downstate program included 250 inpatient beds, a surgical suite with 14 operating rooms (ORs), and one hybrid OR, crucial care units, a cardiology suite with catheterization labs and electrophysiology, an emergency room with trauma, and an urgent care center. Additional outpatient centers within the ASC included a women's health institute, an orthopedics institute, a cardiovascular/stroke clinic, and an endocrine clinic.

- The architectural cost estimate of the initial interpretation of the Brooklyn for Downstate plan ranged $2.65 billion - $2.85 billion in direct capital costs. Soft costs and furniture, fixtures, and equipment (FFE) were not calculated for the hypothetical models.

See Appendix 4-A for additional information on capital cost estimates of hypothetical models.

Final Scenario Selections

Based on the community input gathered and the findings of the statutory factors to be considered, DCAB evaluated a variety of scenarios to explore potential recommendations. The scenarios evaluated included:

Scenario 1 *– Brooklyn for Downstate: New hospital and outpatient buildings*

Brooklyn for Downstate, an advocacy group formed in 2024, released its public report *"Data Analysis & Recommendations for the Future of SUNY Downstate"* in December 2024. The report recommended reducing SUNY Downstate's bed capacity from 342 to 250 beds and called for the enhancement, expansion, or creation of multiple inpatient service lines and outpatient care services. Inpatient services highlighted in the report included expansion of emergency department services to a Level 1 or 2 trauma designation, modernization of maternal/OBGYN programs, expansion of cardiothoracic services, creation of an inpatient oncology service line, and expansion of transplant services. The report also called for the creation of new urgent care centers, ambulatory surgery centers, and outpatient preventive care centers.

Brooklyn for Downstate contracted an architectural firm to develop conceptual renderings based on the report's recommendations. These renderings were publicly released in February 2025 and depicted a new 16-story hospital building located where a substantial portion of the existing SUNY Downstate hospital currently stands. DCAB met with Brooklyn for Downstate on two occasions. During the first meeting, Brooklyn for Downstate and the architectural firm presented a summary of the public report and conceptual renderings. Following this meeting, Brooklyn for Downstate commissioned the architectural firm to further study and model the Brooklyn for Downstate plan. In May 2025, DCAB met again with Brooklyn for Downstate and the architectural firm, who presented five approach options based on the Brooklyn for Downstate plan - each proposing approximately 850,000 square feet of new construction and no investment in the current hospital building. Presented estimated costs ranged from $2.0 billion – 2.7 billion. DCAB selected Options 2 and 5 from the presentation for further modeling, aligning them with the same assumptions used for the other scenarios considered in DCAB's deliberations.

Scenario 1a – Option 2 from Brooklyn for Downstate 5/7/2025 presentation to DCAB. Demolish 3-story section of current hospital and portion of college academic building to build a new 16-story hospital. Include program consistent with Brooklyn for Downstate written recommendations. No investment in the remaining current hospital building.

- Architectural Program Description:
    - The proposed hospital, including inpatient and outpatient services, was modeled by Brooklyn for Downstate as a 16-story building on the 3-story section of current hospital and portion of college academic building, totaling approximately 850,000 building gross square feet (BGSF). The hospital inpatient program included 258 inpatient beds, 12 standard operating rooms (ORs), catheterization labs and electrophysiology, diagnostic imaging, and an ED with 36 treatment bays and 4 observation

units. The hospital outpatient program included a surgical suite with four ORs, 96 exam rooms, imaging capacity, an oncology suite with infusion rooms and a linear accelerator, and urgent care.

  - The program was presented by Brooklyn for Downstate over two phases. Phase 1 included demolition of approximately 75,000 SF of the current hospital and college, including the pharmacy outbuilding, some hospital and campus equipment enclosures, and portion of the Basic Sciences Building. Following Phase 1 construction, Phase 2 demolition included demolition of approximately 195,000 SF of the current hospital, including the current ED, all hospital ORs, surgical suite, radiology, obstetrics, NICU and outpatient space.

  - No upgrades and renovation to the current hospital building were included in Scenario 1a.

- Capital Cost Estimate: The architectural cost estimate of scenario 1a model was $2.7 billion in direct capital costs. When considering soft costs and furniture, fixtures, and equipment (FFE), the total estimated capital project cost is approximately $3.6 billion.

- Financial Operating Model:

  - 85% Occupancy, Currently Reported Economics: Assuming all Scenario 1a facility units operate at 85% occupancy, SUNY Downstate inpatient primary service area (PSA) market share would need to increase from 9% to 16%, and outpatient volume would need to grow by approximately 100%. Based on these assumptions and current-state economic conditions, the projected net income is approximately ($172 million) for inpatient services and ($193 million) for outpatient services, resulting in a total net operating loss of ($365 million).

  - Market-Based Volume, Significantly Improved Economics: Considering historical data on market share, regional demand, and hospital performance, Scenario 1a feasible assumptions include increasing inpatient growth by 14% and outpatient growth by 39%, increasing commercial payor mix by 4%, improvement in commercial reimbursement as a percentage of Medicare to 125%, a 30% contribution margin, and 5% cost reduction. Assuming these improvements are achieved, the projected total net operating loss for Scenario 1a could be approximately ($173 million).

  - 85% Occupancy, Very Optimistic Economics: The upside financial model assumes 85% occupancy, as well as optimistic financial improvements like increasing the commercial payor mix to 22% and reducing costs by 15%.

Assuming these improvements are achieved, the projected total net operating loss for Scenario 1a could be approximately ($155 million). However, this analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.

- See Appendix 4-A for more detail on the scenario 1a model.

Scenario 1b - Option 5 from Brooklyn for Downstate 5/7/2025 presentation to DCAB. Demolish 3-story portion of current hospital and build new, 7-story outpatient building. Build a new 14-story inpatient hospital on Lenox Road parking garage site. Include program consistent with Brooklyn for Downstate written recommendations. No investment in the remaining current hospital building.

- Architectural Program Description:
  - The proposed inpatient hospital was modeled by Brooklyn for Downstate as a 14-story building on the Lenox Road parking garage site, totaling approximately 650,000 building gross square feet (BGSF). The inpatient program included 258 inpatient beds, 12 standard operating rooms (ORs), catheterization labs and electrophysiology, diagnostic imaging, and an ED with 36 treatment bays and 4 observation units.

  - The proposed outpatient building was modeled by Brooklyn for Downstate as a 7-story building on the 3-story section of current hospital, totaling approximately 240,000 building gross square feet (BGSF). The outpatient program included a surgical suite with four ORs, 96 exam rooms, imaging capacity, an oncology suite with infusion rooms and a linear accelerator, and urgent care.

  - The program presented by Brooklyn for Downstate proposed demolition of approximately 195,000 SF of the current hospital, including the current ED, all hospital ORs and surgical suite, radiology, obstetrics, NICU and outpatient space. Once demolished, this site would serve as the site for the new 7-story outpatient building.

  - No upgrades and renovation to the current hospital building were included in Scenario 1b.

- Capital Cost Estimate: The architectural cost estimate of scenario 1b model was $2.8 billion in direct capital costs. When considering soft costs and furniture, fixtures, and equipment (FFE), the total estimated capital project cost is approximately $3.8 billion.

- Financial Operating Model:
    - 85% Occupancy, Currently Reported Economics: Due to their matching programs, the Scenario 1b current-state economic model is same as Scenario 1a, resulting in a total net operating loss of ($365 million).
    - Market-Based Volume, Significantly Improved Economics: Due to their matching programs, the Scenario 1b feasible improvements model is the same as Scenario 1a, where, assuming these improvements are achieved, the projected total net operating loss for Scenario 1b could be approximately ($173 million).
    - 85% Occupancy, Very Optimistic Economics: Due to their matching programs, the Scenario 1b upside improvements model is same as Scenario 1a, where, assuming optimistic improvements like increasing the commercial payor mix to 22% and reducing costs by 15% are achieved, the projected total net operating loss for Scenario 1b could be approximately ($155 million). However, this analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.
- See Appendix 4-A for more detail on the scenario 1b model.

Scenario 2 – *Current hospital renovation and new ambulatory surgery center*

Scenario 2 includes renovating the current hospital building to maintain inpatient and emergency services, as well as the construction of a new ambulatory surgery center (ASC) specializing in cardiology and oncology services. The new ASC would include a modern surgical platform to accommodate advanced outpatient procedures, dedicated cardiology and oncology suites, and general outpatient exam and procedure space. The current hospital building would undergo prioritized repairs and renovations, including upgrades to mechanical, electrical, and plumbing (MEP) systems, modernization of the emergency department, and conversion of patient rooms to single-occupancy units with private toilets and showers.

Multiple decision factors of scenario 2 were considered, including the number of patient rooms to be renovated, if the ED should be modernized to current bay capacity or expanded to additional bay capacity, and if the ASC should be built with future expansion capacity.

- Architectural Program Description:
    - Modeled upgrades and renovation to the current hospital building included repair and replacement of all prioritized MEP systems. The existing ED modernization was modeled in two variations: right sized to maintain its current capacity of 38 treatment bays and expanded from 38 bays to 45

bays. All inpatient rooms were modeled for conversion to single-occupancy units with private toilets and showers.

  - The proposed ASC was modeled as a 4-story building on the Lenox Road parking garage site, totaling approximately 150,000 building gross square feet (BGSF). The ASC program included a surgical suite with five operating rooms (ORs), one hybrid OR, and 18 pre-post beds. It also featured a cardiology suite with catheterization labs and interventional radiology, and an oncology suite equipped with infusion rooms, advanced imaging, and a linear accelerator. Additional program components included general imaging, exam rooms, and procedure space.

- Capital Cost Estimate: The architectural cost estimate of Scenario 2 ranged $750 million - $825 million in direct capital costs, including approximately $460 million for the new ASC and $452 million for renovations to the current hospital building. $125 million in MEP costs was deducted from the final renovation cost estimate considering current hospital projects that overlap with the MEP systems DCAB analysis identified for repair. When considering soft costs and furniture, fixtures, and equipment (FFE), the total estimated capital project cost is approximately $1.0 billion.

- Financial Operating Model:

  - 85% Occupancy, Currently Reported Economics: Assuming all Scenario 2 facility units operate at 85% occupancy, SUNY Downstate's inpatient primary service area (PSA) market share would need to increase from 9% to 10%, and outpatient volume would need to grow by approximately 60%. Based on these assumptions and current-state economic conditions, the projected net income is approximately ($10 million) for inpatient services and ($167 million) for outpatient services, resulting in a total net operating loss of ($178 million).

  - Market-Based Volume, Significantly Improved Economics: Considering historical data on market share, regional demand, and hospital performance, Scenario 2 feasible assumptions include increasing inpatient growth by 4% and outpatient growth by 16%, increasing commercial payor mix by 1%, improvement in commercial reimbursement as a percentage of Medicare to 125%, a 30% contribution margin, and 8% cost reduction. Assuming these improvements are achieved, the projected total net operating loss for Scenario 2 could be approximately ($83 million).

  - 85% Occupancy, Very Optimistic Economics: The upside financial model assumes 85% occupancy, as well as optimistic financial improvements like increasing the commercial payor mix to 22% and reducing costs by 15%. Assuming these improvements are achieved, the projected total net operating loss for Scenario 2 could be approximately ($31 million).

However, this analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.

- See Appendix 4-A for more detail on the scenario 2 model.

Scenario 3 – *New advanced diagnostic & treatment center emphasis*

Scenario 3 primarily focuses on the development of a new advanced diagnostic & treatment center (D&T), with limited investment in the current hospital building and varied approaches to inpatient and emergency services. The new D&T would include a large surgical platform to support advanced outpatient procedures, along with dedicated suites for cardiology, oncology, women's health, orthopedics, endocrinology, and general outpatient exam and procedure space. Approaches to inpatient and emergency services vary across sub-scenarios, with both having a shared emphasis to limit investment in the current hospital building.

Scenario 3a – New advanced diagnostic & treatment center with subterranean parking on Lenox Road parking garage site, new 100-200 inpatient bed tower on Lenox Road nursing residence site, limited investment in current hospital building to update identified MEP systems and minor ED renovation to reduced capacity.

- Architectural Program Description:
  - The proposed D&T was modeled as a 6-story building on the Lenox Road parking garage site with two floors of subterranean parking, totaling approximately 400,000 building gross square feet (BGSF). The D&T program included a surgical suite with nine operating rooms (ORs), one hybrid OR, and 30 pre-post beds, a cardiology suite with catheterization labs and electrophysiology, and an oncology suite with infusion rooms, advanced imaging, a linear accelerator, and brachytherapy. Additional outpatient centers within the D&T included women's health, orthopedics, endocrinology, as well as general imaging, exam rooms, and procedure space.

  - The proposed 100-200 inpatient bed tower was modeled as a 6- to 10-story building on the Lenox Road nursing residence site, totaling approximately 250,000 – 400,000 building gross square feet (BGSF). The bed tower included 100-200 universal inpatient beds, general administrative support areas, and a main lobby. The design incorporated two enclosed bridge connections: one linking the inpatient bed tower to the new D&T, and another connecting the inpatient bed tower to the current hospital building.

  - Modeled upgrades and renovation to the current hospital building included repair and replacement of all prioritized MEP systems. The existing ED was modeled for renovation and downsizing, reducing the treatment bay count from 38 to approximately 21.

- Capital Cost Estimate: The architectural cost estimate of scenario 3a model was $2.0 billion - $2.7 billion in direct capital costs. This includes approximately $1.1 billion for the new D&T; $537 million – $1.0 billion for the new inpatient bed tower, depending on whether the 100- or 200- bed option is selected; and $332 million for renovations to the current hospital building. $125 million in MEP costs was deducted from the final renovation cost estimate considering current hospital projects that overlap with the MEP systems DCAB analysis identified for repair. When considering soft costs and furniture, fixtures, and equipment (FFE), the total estimated capital project cost is approximately $3.2 billion.

- Financial Operating Model:

    - 85% Occupancy, Currently Reported Economics: Assuming all Scenario 3a facility units operate at 85% occupancy, SUNY Downstate inpatient primary service area (PSA) market share would need to increase from 9% to 11%, and outpatient volume would need to grow by approximately 140%. Based on these assumptions and current-state economic conditions, the projected net income is approximately ($48 million) for inpatient services and ($305 million) for outpatient services, resulting in a total net operating loss of ($353 million).

    - Market-Based Volume, Significantly Improved Economics: Considering historical data on market share, regional demand, and hospital performance, Scenario 3a feasible assumptions include increasing inpatient growth by 4% and outpatient growth by 39%, increasing commercial payor mix by 4%, improvement in commercial reimbursement as a percentage of Medicare to 125%, a 30% contribution margin, and 8% cost reduction. Assuming these improvements are achieved, the projected total net operating loss for Scenario 3a could be approximately ($117 million).

    - 85% Occupancy, Very Optimistic Economics: The upside financial model assumes 85% occupancy, as well as optimistic financial improvements like increasing the commercial payor mix to 30% and reducing costs by 15%. Assuming these improvements are achieved, the projected total net operating loss for Scenario 3a could be approximately ($143 million). However, this analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.

- See Appendix 4-A for more detail on the scenario 3a model.

Scenario 3b – New advanced diagnostic & treatment center, no investment in current hospital building.

- Architectural Program Description:
    - The proposed D&T was modeled as a 5-story building on the Lenox Road parking garage site, totaling approximately 250,000 building gross square feet (BGSF). The D&T program included a surgical suite with nine operating rooms (ORs), one hybrid OR, and 30 pre-post beds, a cardiology suite with catheterization labs and electrophysiology, and an oncology suite with infusion rooms, advanced imaging, a linear accelerator, and brachytherapy. Additional outpatient centers within the D&T included women's health, orthopedics, endocrinology, as well as general imaging, exam rooms, and procedure space. The women's health outpatient center was modeled at about half the size of the 3a version.

    - No upgrades and renovation to the current hospital building were included in Scenario 3b.

- Capital Cost Estimate: The architectural cost estimate of scenario 3b model was $662 million - $765 million in direct capital costs. When considering soft costs and furniture, fixtures, and equipment (FFE), the total estimated capital project cost is approximately $991 million.

- Financial Operating Model:

    - 85% Occupancy, Currently Reported Economics: Assuming all Scenario 3b facility units operate at 85% occupancy, SUNY Downstate inpatient primary service area (PSA) market share would need to increase from 9% to 10%, and outpatient volume would need to grow by approximately 140%. Based on these assumptions and current-state economic conditions, the projected net income is approximately ($32 million) for inpatient services and ($261 million) for outpatient services, resulting in a total net operating loss of ($292 million).

    - Market-Based Volume, Significantly Improved Economics: Considering historical data on market share, regional demand, and hospital performance, Scenario 3b feasible assumptions include increasing inpatient growth by 6% and outpatient growth by 39%, increasing commercial payor mix by 3%, improvement in commercial reimbursement as a percentage of Medicare to 125%, a 30% contribution margin, and 8% cost reduction. Assuming these improvements are achieved, the projected total net operating loss for Scenario 3b could be approximately ($132 million).

    - 85% Occupancy, Very Optimistic Economics: The upside financial model assumes 85% occupancy, as well as optimistic financial improvements like increasing the commercial payor mix to 22% and reducing costs by 15%.

Assuming these improvements are achieved, the projected total net operating loss for Scenario 3b could be approximately ($114 million). However, this analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.

- See Appendix 4-A for more detail on the scenario 3b model.

Scenario 4 *– Phased collaboration with Kings County emphasis, with Scenario 2 capital model*

A fourth scenario focused on a phased collaboration with NYC Health + Hospitals/Kings County Hospital Center with the Scenario 2 capital model was originally considered.

The Scenario 4 collaboration model proposed SUNY Downstate would transition lower acuity services to Kings County, and Kings County would refer higher-acuity, specialty cases to SUNY Downstate. This would enable SUNY Downstate, as an academic medical center, to expand its volume in more advanced medical and surgical subspecialties, such as cardiology, oncology, urology, gastroenterology, and rheumatology.

Specifically, Scenario 4 assumed all Kings County oncology volume and the top 15% highest-acuity volume in cardiology, urology, gastrointestinal, and rheumatology would shift to SUNY Downstate, and all SUNY Downstate labor and delivery, obstetrics, gynecology, and neonatology volume would shift to Kings County.

- Architectural Program Description:
  - Refer to Scenario 2 program description, which includes hospital renovation and the construction of a new 4-story ASC on the Lenox Road parking garage site.

- Capital Cost Estimate: Refer to Scenario 2 capital cost estimate. The architectural cost estimate of Scenario 2 ranged $750 million - $825 million in direct capital costs, including approximately $460 million for the new ASC and $452 million for renovations to the current hospital building. $125 million in MEP costs was deducted from the final renovation cost estimate considering current hospital projects that overlap with the MEP systems DCAB analysis identified for repair. When considering soft costs and furniture, fixtures, and equipment (FFE), the total estimated capital project cost is approximately $1.0 billion.

- Financial Operating Model:

  - 85% Occupancy, Currently Reported Economics: : Assuming all facility units operate at 85% occupancy, SUNY Downstate inpatient primary service area (PSA) market share would remain at 9%, and outpatient volume would need to grow by approximately 40%. Based on these assumptions, combined with the phased Kings County collaboration approach and current-state economic conditions, the projected net income

is approximately $36 million for inpatient services and ($144 million) for outpatient services, resulting in a total net operating loss of ($108 million).

- Market-Based Volume, Significantly Improved Economics: Considering historical data on market share, regional demand, and hospital performance, Scenario 4 feasible assumptions include increasing inpatient growth by 4% and outpatient growth by 16%, increasing commercial payor mix by 1%, improvement in commercial reimbursement as a percentage of Medicare to 125%, a 30% contribution margin, and 10% cost reduction. Assuming these improvements are achieved, the projected total net operating loss for Scenario 3b could be approximately ($43 million).

- 85% Occupancy, Very Optimistic Economics: The upside financial model assumes 85% occupancy, as well as optimistic financial improvements like increasing the commercial payor mix to 22% and reducing costs by 15%. Assuming these improvements are achieved, the projected total net operating income for Scenario 4 could be approximately $38 million. However, this analysis reflects a level of change that is overly ambitious and likely unattainable, at least over the coming years.

See Appendix 4-A for more detail on the original scenario 4 model.

Attachment A
DCAB Recommendations Summary

Downstate Community Advisory Board

Background

- The Community Advisory Board for the Modernization and Revitalization of SUNY Downstate was created by law in 2024 and includes **nine appointed members**.
- The advisory board was charged with completing a study and providing written recommendations to **prioritize healthcare services** provided in the SUNY Downstate service area.
- The recommendations are required to include a **reasonable, scalable and fiscally responsible plan** for the financial health, viability and sustainability of SUNY Downstate.

Robust Community Process

Over the course of their deliberations, the advisory board:

- Held **four public hearings** (one more than statutorily required) on January 22, February 27, March 13, and April 28. The approach now recommended by the advisory board was presented to the public as an option under consideration at the fourth public hearing.
- Met with numerous **community stakeholders** including the SUNY Downstate Medical School Department Chairs, Brooklyn for Downstate, the leadership at SUNY Downstate, and other regional healthcare providers.
- Carefully **reviewed analysis** of the community health needs, Downstate Hospital's financials, and the condition of Downstate Hospital's physical plant.
- Engaged a **team of consultants** to provide expert analysis, infrastructure assessment, financial modeling, architectural and engineering scenarios, and coordination.

High Level Recommendations

Current Hospital Reinvestment

- **Retain inpatient and outpatient services**
- Address mechanical, electrical, and plumbing infrastructure issues
- Right-size and convert all double occupancy rooms to private rooms with showers*
- Modernize and expand the emergency department
- Renovate and modernize the dedicated inpatient specialty units, including cardiology, oncology, and orthopedics**

Build New Annex Including Ambulatory Surgery Center

- Brand new hospital annex, including state-of-the-art ambulatory surgery center
- Expand and focus on oncology and cardiology
- Build for future expansion for community needs
- Include parking

Leadership & Operations

- Hospital & Campus Accountability
- Financial feasibility actions
- Strategic collaborations
- New electronic health record
- Improved health quality and service outcomes
- Effective Marketing

*Includes updating nursing stations, central core support, and dedicated specialty units

**in addition to the recent upgrades to maternity and transplant services

Current Hospital Reinvestment Overall

Current

- Inpatient, outpatient, emergency, primary care and specialty services
  - Valued and unique services and designations, like the kidney transplant program and Regional Perinatal Center Designation
- 342 certified beds, only 24 are private
- 165 average daily census

Recommended

- Maintain all current service lines, with emphasis on higher acuity and elective surgery
- 225 operational beds, reflecting a conversion of all beds to single-occupancy private rooms with showers
- Goal to expand beyond 165 average daily census
- Establish dedicated inpatient specialty services to include cardiology, oncology, and orthopedics

In addition to interior renovation, the recommended Current Hospital Reinvestment project includes exterior envelope upgrades. Existing windows allow excessive air and moisture into the building, which can compromise infection control and disrupt patient recovery. External envelope upgrades will address these issues and replace the existing windows with properly sealed units.

Current Hospital Reinvestment Mechanical, Electrical, Plumbing (MEP)

Current

- Distribution systems connecting mechanical equipment rooms to hospital spaces are in poor condition
  - Includes piping, ductwork, and electrical conduit that run throughout the patient and clinical spaces in the hospital
- Aging distribution infrastructure has led to repeated failures like flooding, temperature control issues, and emergency system shutdowns – all disrupting operations

Recommended

- Fully address mechanical, electrical, plumbing (MEP) needs throughout the entire Hospital
  - Includes new piping, medical gas distribution systems, sprinkler systems, ductwork, heating/cooling, and more.
- Comprehensively addressing MEP will support patient & staff safety, reliability of systems, and uninterrupted patient care operations

The hospital's MEP distribution systems, original to its 1966 construction, are in distress due to corrosion and/or have exceeded their expected lifespan. Several systems are at risk for failure. Comprehensive rehabilitation and replacement of MEP systems throughout the hospital will address this.

Current Hospital Reinvestment
Private Patient Rooms

Current

- Vast majority of beds are in double-occupancy rooms with inaccessible toilet and/or showers, inadequate clearance around beds, and minimal space for family/visitor seating
- Critical care units configured in an open ward style, with inadequate bed clearance and no direct access to toilets
- Only 35 private rooms with toilets & showers exist now
  - 24 in the kidney transplant unit
  - 11 more under construction in labor and delivery
- OR renovations completed Spring 2025

Recommended

- Renovate all inpatient beds to become single-occupancy, private rooms with toilets & showers
  - Includes all med/surg and critical care units (ICU, PICU)
  - Renovation will result in 225 patient rooms that meet modern standards of care and support healing
- Upgrades will include renovated nurse stations and central core support
- Renovations will include existing inpatient dedicated specialty units, plus cardiology and oncology

Current Hospital Patient Room

Current Hospital Reinvestment
Private Patient Rooms

Renovated Hospital Patient Room Vision

Current Hospital Reinvestment
Modernized and Expanded Emergency Department

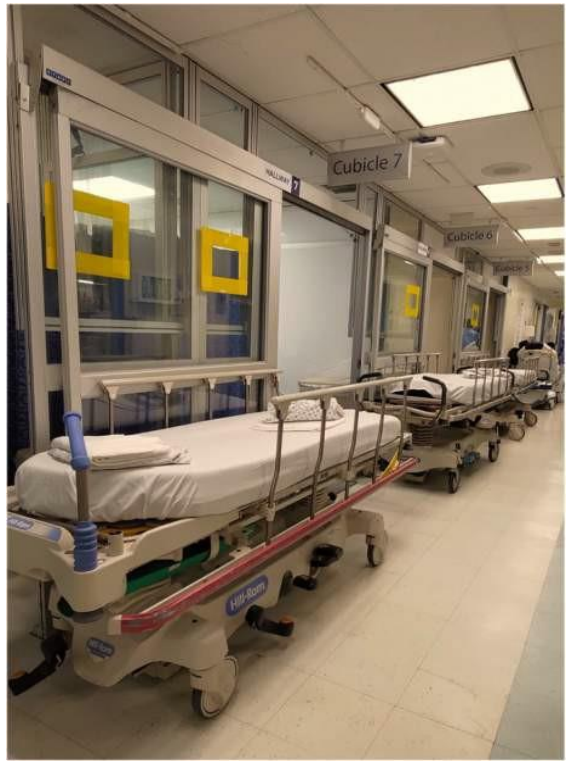
Current

- 38 stations in outdated, undersized, and overcrowded space
- Poor circulation among ED sections and between imaging

Recommended

- Modernize, redesign, and expand the ED to reduce crowding and improve patient flow for operational efficiency
- Expand to 45 stations, including 42 treatment bays and 3 observation beds for additional capacity

Current Hospital Emergency Department



Current Hospital Reinvestment
Modernized and Expanded Emergency Department

Renovated Hospital Emergency Department Vision

Current Hospital Reinvestment Floor by Floor

Expanded Emergency Dept (Existing Hospital)			
45 Stations 550-650 SF/station	(existing) 38 stations	low 24,750 SF	high 29,250 SF
Outpatient (former Emergency Department space)			
11,300 SF	Exam Rooms	16	23
Patient Floor Rehab (Existing Hospital) Standard Single Rooms & Toilet Room w/ Sink & Shower			
Level 8 (w/Transplant MEP only)	(existing) 66 beds	reno 18 rooms/24 ETR	new total **44 beds**
Level 7 22,000 SF	(existing) 76 beds	reno 36 rooms	new total **42 beds**
Level 6 22,000 SF	(existing) 74 beds	reno 38 rooms	new total **42 beds**
Level 5 (partial) 17,550 SF	(existing) outpatient	reno 33 rooms	new total **33 beds**
Level 4 PEDS Beds - 9,710 SF	(existing) 22 beds	reno 12 rooms	new total **13 beds**
Level 4 PICU - 2,700 SF	(existing) 5 beds	**5 beds**	
Level 3 OBGYN Beds	under renovation		new total **11 beds**
Level 3 MICU - 4,450 SF	(existing) 10 beds	low **6 beds**	high **7 beds**
Level 3 NICU - expanded 8,450 SF	(existing) 29 stations	new total **13 beds**	
Level 2 CCU - 4,000 SF	(existing) 7 beds	low **5 beds**	high **6 beds**
Level 2 CT CCU - 5,610 SF	(existing) 9 beds	low **7 beds**	high **9 beds**
Specialty Care Unit Upgrades			
Resulting Single Bed Room Count		**225**	

Convert all existing patient rooms to private with bathrooms/showers

As part of the renovation, all nursing stations on floors 2-8 will also be renovated as well as the core support

Modernize and expand the emergency department

13 of these rooms will be added following completion of ED renovation and movement of existing outpatient services on level 5

Renovate and modernize dedicated specialty units, including cardiology, oncology, and orthopedics

Build New Downstate Annex Overall

The top two leading causes of death for Brooklyn residents are cancer and heart disease – new ASC will focus on these, attract new patients (including commercial payors), and provide referrals to the hospital

- This state-of-the-art, four-story ambulatory surgery center will expand access to high-quality care for cancer and heart disease
- Will be built on the state-owned Lenox Road site currently occupied by the condemned parking garage across from the hospital
- Not only will the Downstate Annex provide critically needed cardiology and oncology services, but it will importantly increase hospital usage through referrals

Build New Downstate Annex

Surgery

• ORs	5
• Hybrid OR	1
• Pre-Post	18

Cardiology

• Cath Labs	2
• IR	1
• Procedure Rooms	3

Oncology

Infusion

• Infusion Rooms	6

Imaging

• Mammography	2
• CT Sim	1
• PET CT	1

Treatment

• Linac	1

Imaging

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

Procedure Suite

• Procedure Rooms	2

Outpatient

Faculty Exam

• Exam Rooms	24

Build New Downstate Annex
Designed for the Community & Future Needs

Abundant light and green space adjacent to oncology infusion rooms offers patients a calming view and connection to nature during extended treatment sessions

Window spacing and design reflect the architectural language of the existing hospital, creating visual continuity across facilities

The lobby's floor-to-ceiling windows flood the space with natural light, and offers an inviting, welcoming atmosphere for patients and families

Green space offers a peaceful area for families awaiting loved ones in surgery

The new Downstate Annex will be designed with future expansion in mind. Reinforced structural infrastructure will support potential vertical additions, and floor layouts will be planned to enable future horizontal expansion or bridge connections with minimal disruption to patient care spaces

Leadership & Operations

Accountability & Culture	New Electronic Health Record*	Improve Quality of Care	Effective Marketing	Strengthen Collaboration
• Hospital, campus, & practice plans • Clear expectations • Measurement • Alignment • Execution	• Modernize system • Integrate systems • Improve quality and operations • Increase revenue and enhance provider and patient experience	• Key component of reinvestment plan • Raise expectations • Prioritize • Deliver results • Attract patients	• Develop plan • Actively promote vision • Communicate progress • Improve fundraising • Attract patients	• Enhance current affiliations • Develop new partnerships (FQHCs, others) • Explore strategic partnerships

As part of working toward financial feasibility need dedicated and dynamic team focused on planning, achieving volume increases, shifting payer mix and payment rates, and reducing cost structure

*Funded by a different source

Capital Funding

Available funding includes $750 million in DCAB capital, assumption of annual $50 million capital maintenance appropriations over the next 7 years ($350 million), and adjustments for projects already planned and funded

	Capital Construction Midpoint Estimate	Soft Capital Cost Estimate	Total Capital Cost Estimate
Hospital Renovation	$496 million		
Hospital Annex	$460 million		
Total	$956 million		
Total less overlap MEP	$831 million	$287 million	$1,118 million

*$125 million in MEP-related costs was deducted from the cost estimate considering current hospital projects that overlap with the MEP systems DCAB analysis identified for repair

Financial Feasibility

Projection	Actual 2023 Underlying Net Income	85% Occupancy, Currently Reported Economics	Market Based Volume, Significantly Improved Economics	85% Occupancy, Very Optimistic Economics
Operating Income	($95 million)	($181 million)	($86 million)	($20 million)

None of the above includes state subsidies toward deficit understanding the current high government payor mix of around 90%

Financial Feasibility Assumptions

Projection	85% Occupancy, Currently Reported Economics	Market Based Volume, Significantly Improved Economics	85% Occupancy, Very Optimistic Economics
Operating Income	• Volume is increased to reach 85% occupancy at hospital and annex • PSA market share increases from 9% to 10% • Outpatient volume grows approximately 60% growth • No changes in cost structure and operations	• 4% inpatient volume growth • 16% growth in outpatient volume growth • 11% commercial payor mix • Commercial rates that approximate 125% of Medicare • 8% reduction in overhead costs • Contribution margin of 30% that limits expense growth as volume increases	• Longer term strive to further improve operating deficit toward upside scenario, but this is highly ambitious • Volume is increased to reach 85% occupancy at hospital and annex • PSA market share increases from 9% to 10% • Outpatient volume grows approximately 60% growth • 22% commercial payor mix • 15% reduction in costs • Commercial rates that approximate 125% of Medicare

Attachment B
DCAB Recommendations – Infrastructure and Financial/Operating

High Level Recommendations

Current Hospital Reinvestment

- **Retain inpatient and outpatient services**
- Address mechanical, electrical, and plumbing infrastructure issues
- Right-size and convert all double occupancy rooms to private rooms with showers*
- Modernize and expand the emergency department
- Renovate and modernize the dedicated inpatient specialty units, including cardiology, oncology, and orthopedics**

Build New Annex Including Ambulatory Surgery Center

- Brand new hospital annex, including state-of-the-art ambulatory surgery center
- Expand and focus on oncology and cardiology
- Build for future expansion for community needs
- Include parking

Leadership & Operations

- Hospital & Campus Accountability
- Financial feasibility actions
- Strategic collaborations
- New electronic health record
- Improved health quality and service outcomes
- Effective Marketing

*Includes updating nursing stations, central core support, and dedicated specialty units

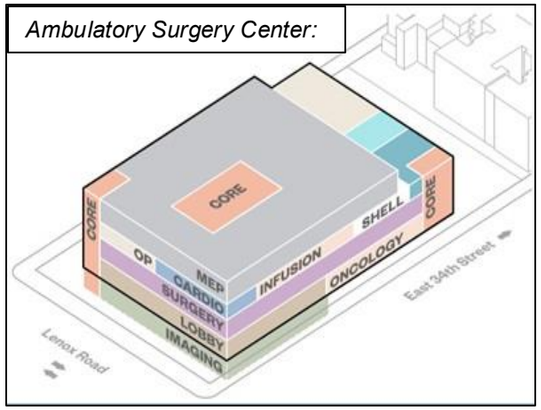
**in addition to the recent upgrades to maternity and transplant services

Infrastructure

DCAB RECOMMENDATION

Recommendation

Ambulatory Surgery Center:



Existing Hospital renovations:
- *E*xpand the ED to 42 stations + 3 obs
- Renovate all Med/Surg Patient Rooms to single occupancy
- Right-size CCU beds
- MEP upgrades throughout Hospital

Construct New Ambulatory Surgery Center

COST MODELING

PRELIMINARY COST MODEL	$918,152,333	$993,868,821
minus $125M*	$793,152,333	$868,868,821
Total Anticipated SOFT COSTS	+/- $287,000,000	

*Considers current MEP projects underway

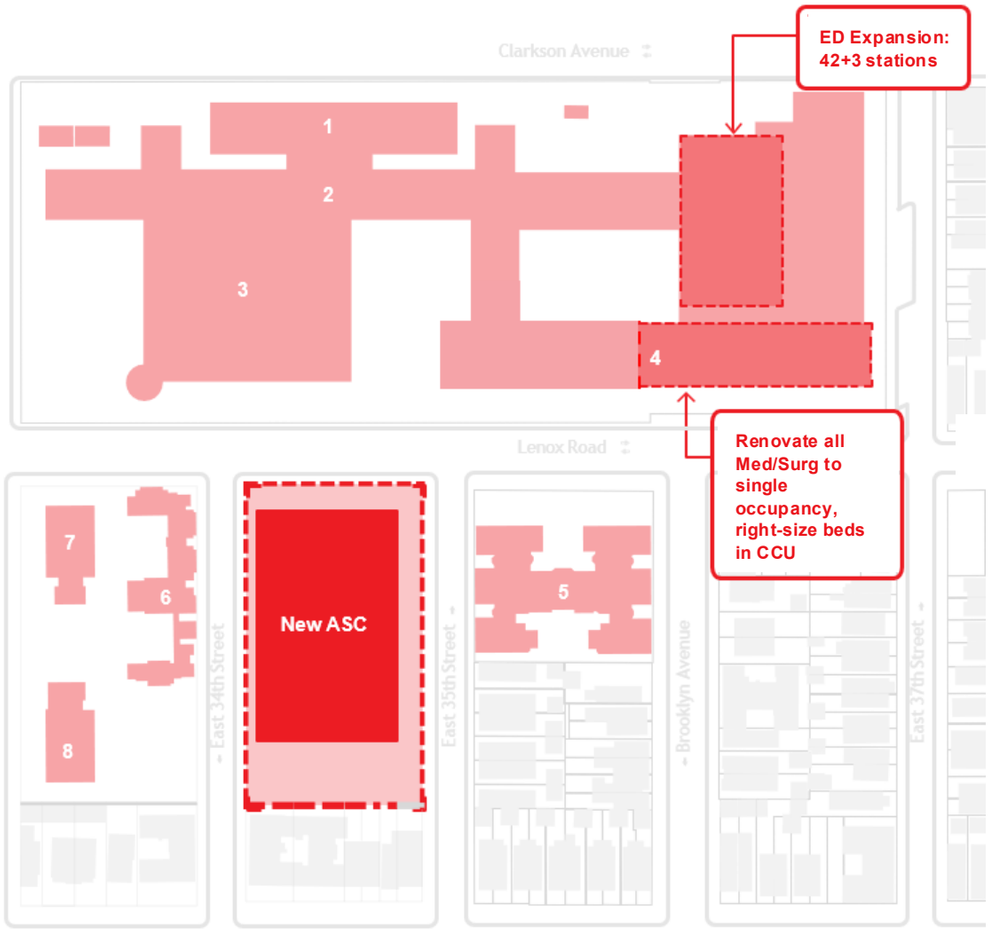
TOTAL COST ESTIMATE	$1,080,152,333	1,155,868,821

Total project duration is +/- 7 years

DCAB RECOMMENDATION

Recommendation

- Hospital renovation of all Medical/Surgical Inpatient Rooms for conversion to single occupancy with private toilet/shower/sink. Includes renovation of entire unit including nurse stations and core support areas.
- Hospital renovation of Critical Care Units to right-size care stations Includes renovation of entire unit including nurse stations and core support areas.
- Hospital ED expansion to right-size for 42+3 stations
- Hospital exterior building improvements / upgrades
- MEP upgrades throughout hospital
- Construct new Ambulatory Surgery Center on current parking garage site with infrastructure to support future expansion. Includes imaging, procedure rooms, ambulatory surgery, and outpatient clinics



DCAB RECOMMENDATION

KEY DRIVERS

Floors:

4

+1 Basements

Surgery

• ORs	5
• Hybrid OR	1
• Pre-Post	18

Cardiology

• Cath Labs	2
• IR	1
• Procedure Rooms	3

Oncology

Infusion

• Infusion Rooms	6

Imaging

• Mammography	2
• CT Sim	1
• PET CT	1

Treatment

• Linac	1

Emergency

• Exams Bays	42
• Observation	3

**** Renovated + Expanded***

Imaging

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

Procedure Suite

• Procedure Rooms	2

Outpatient

Faculty Exam

• Exam Rooms	24

Inpatient

• Beds	225

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

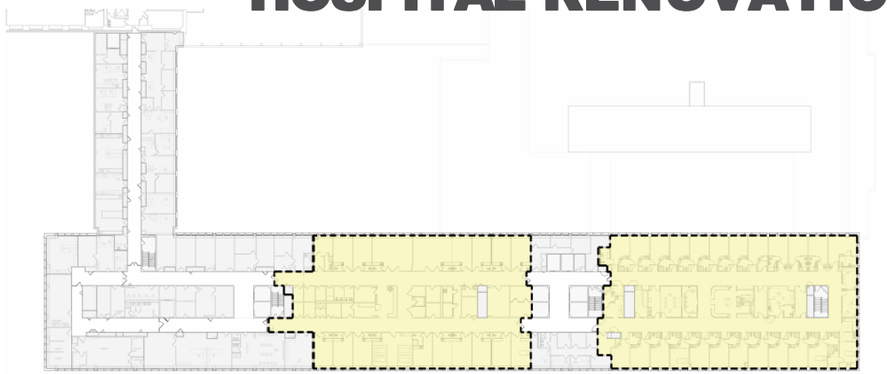
Outpatient

• Exam Rooms	16-23

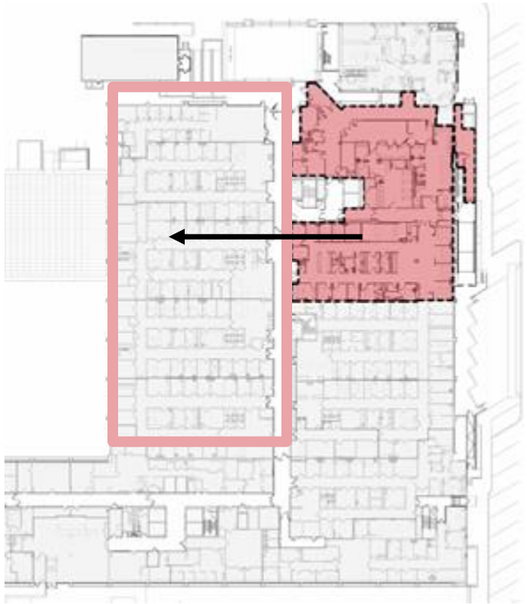
** Some Current ED Space To Be Converted Into Outpatient Space Once New Expanded ED Completed*

DCAB RECOMMENDATION

HOSPITAL RENOVATIONS



Hospital renovation of Inpatient units for Single Occupancy Med/Surg and right-sized Critical Care stations

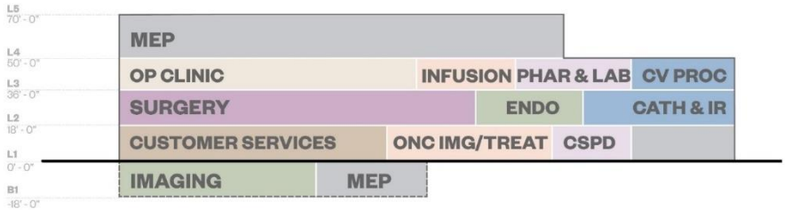


Hospital renovation for expanded, right-sized Emergency Department (45 stations).
Some current ED Space To Be Converted Into Outpatient Space Once New Expanded ED Completed

HOSPITAL ANNEX - ASC

STACKING DIAGRAM

East 34th Street



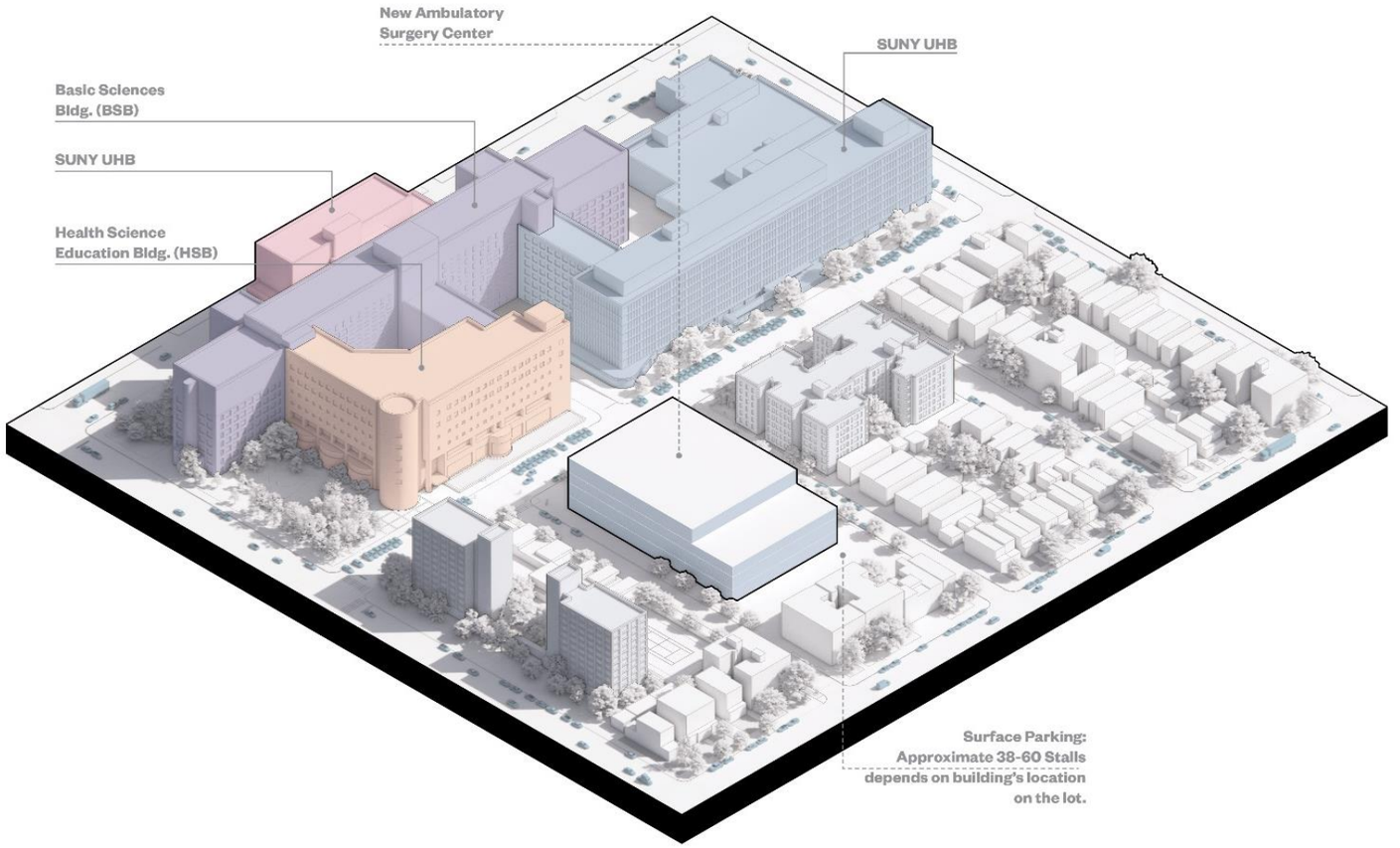
PROGRAM LEGEND

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

Totals

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

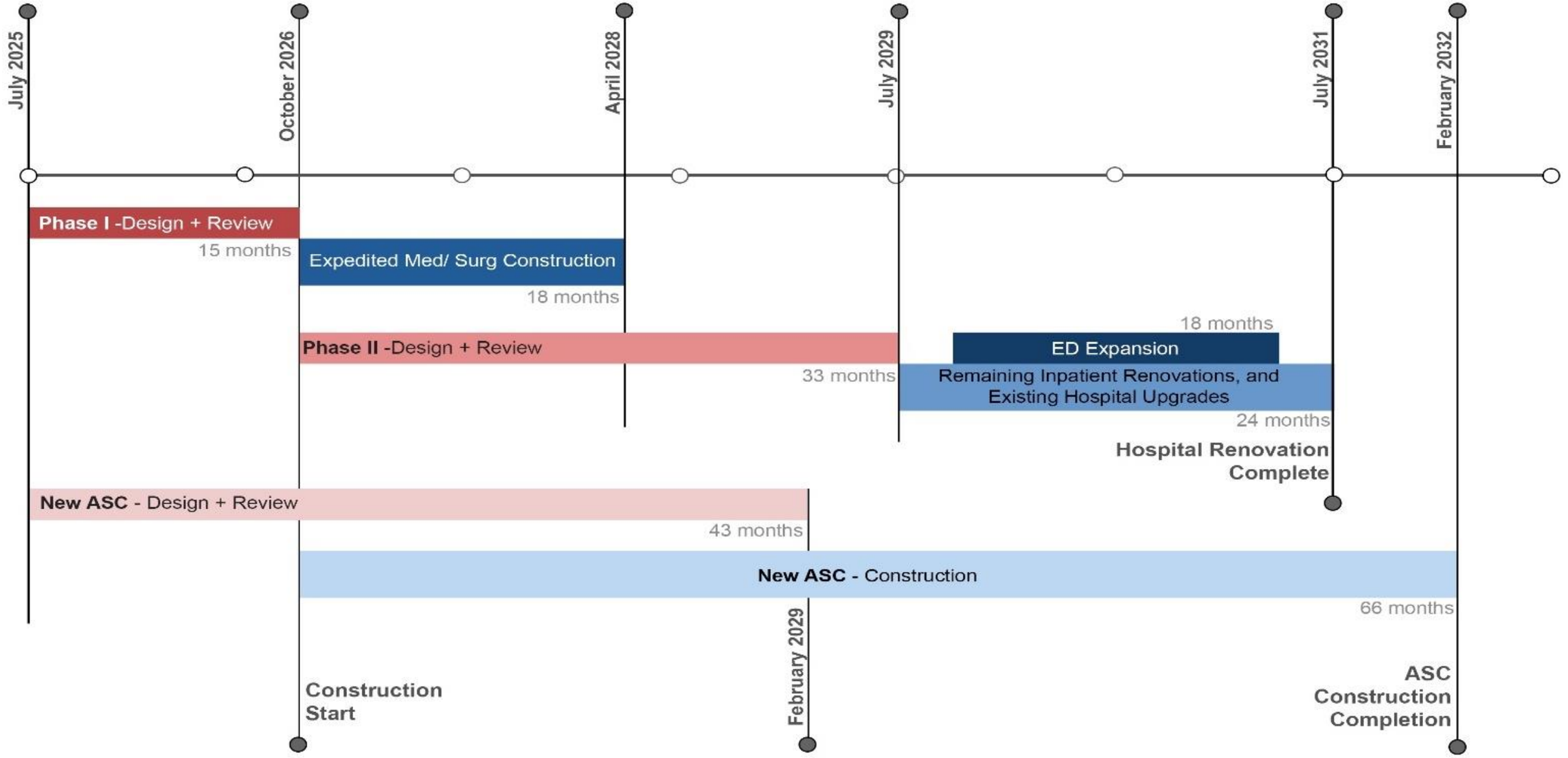
ASC - CONTEXT


New Ambulatory
Surgery Center
SUNY UHB
Basic Sciences
Bldg. (BSB)
SUNY UHB
Health Science
Education Bldg. (HSB)
Surface Parking:
Approximate 38-60 Stalls
depends on building's location
on the lot.

DCAB RECOMMENDATION

						low $2,000/SF	high $2,300/SF
Lobby / Café Imaging Surgery / Procedure Oncology Cardiology Outpatient / Clinic Clinical Support Facilities Support		**New ASC**					
		Building Gross SF			**150,064**	$300,128,000	$345,147,200
		Infrastructure upgrade				$6,000,000	$8,000,000
		Site, Utilities, Plantings			allowance	$15,000,000	$20,000,000
					escalation (5%) construction midpoint	$103,996,999	$120,843,368
					New ASC Total	**$425,124,999**	**$493,990,568**
MEP Upgrade Exterior envelope upgrades Emergency Department (expanded for 45 stations) Med/Surg Patient Rooms (Levels 4,6-8) (conversion to single occupancy w/ toilet/shower room) Med/Surg Patient Rooms (partial Level 5) (conversion to single occupancy w/ toilet/shower room) Critical Care Units (Levels 3 & 4) (right-sized bed count within existing footprint *) Conversion of former Emergency Department to Outpatient Clinic space		**Existing Hospital Upgrades**					
		Site, Roofs, Building Envelope Upgrades				**$41,553,207**	
		Upgrade MEP (Existing Hospital, balance of)				**$195,474,650**	
		Expanded Emergency Dept (Existing Hospital)				$1,150/SF (includes MEP)	
		45 Stations 550-650 SF/station	(existing) 38 stations	low 24,750 SF	high 29,250 SF	**$28,462,500**	**$33,637,500**
		Outpatient (former Emergency Department space, Existing Hospital)				$700/SF (includes MEP)	
		11,300 SF	Exam Rooms	16	23	**$7,910,000**	
	INPATIENT ROOMS Resulting bed count: **225**	**Patient Floor Rehab (Existing Hospital)** Standard Single Rooms & Toilet Room w/ Sink & Shower				(includes MEP)	
		Level 8 (w/Transplant MEP only)	(existing) 66 beds	reno 18 rooms/24 ETR	new total **44 beds**	**$12,008,500**	
		Level 7 22,000 SF	(existing) 76 beds	reno 36 rooms	new total **42 beds**	**$19,360,000**	
		Level 6 22,000 SF	(existing) 74 beds	reno 38 rooms	new total **42 beds**	**$19,360,000**	
		Level 5 (partial) 17,550 SF	(existing) outpatient	reno 33 rooms	new total **33 beds**	**$15,444,000**	
		Level 4 PEDS Beds - 9,710 SF	(existing) 22 beds	reno 12 rooms	new total **13 beds**	**$8,739,000**	
		Level 4 PICU - 2,700 SF	(existing) 5 beds	**5 beds**		**MEP ONLY**	
		Level 3 OBGYN Beds	under renovation		new total **11 beds**	**MEP ONLY**	
		Level 3 MICU - 4,450 SF	(existing) 10 beds	low **6 beds**	high **7 beds**	**$4,895,000**	
		Level 3 NICU - expanded 8,450 SF	(existing) 29 stations	new total **13 beds**		**$9,295,000**	
		Level 2 CCU - 4,000 SF	(existing) 7 beds	low **5 beds**	high **6 beds**	**$4,400,000**	
		Level 2 CT CCU - 5,610 SF	(existing) 9 beds	low **7 beds**	high **9 beds**	**$6,171,000**	
		Specialty Care Unit Upgrades				$10,000,000	
		Resulting Single Bed Room Count		**225**			
					escalation (5%) construction midpoint with accelerated phase	$109,954,477	$111,630,396
					Existing Hospital Renovation Total	**$493,027,334**	**$499,878,253**
					DCAB RECOMMENDATION PRELIMINARY COST MODEL	**$918,152,333**	**$993,868,821**
					minus $125M (Current MEP projects underway) **TOTAL**	**$793,152,333**	**$868,868,821**

DCAB RECOMMENDATION

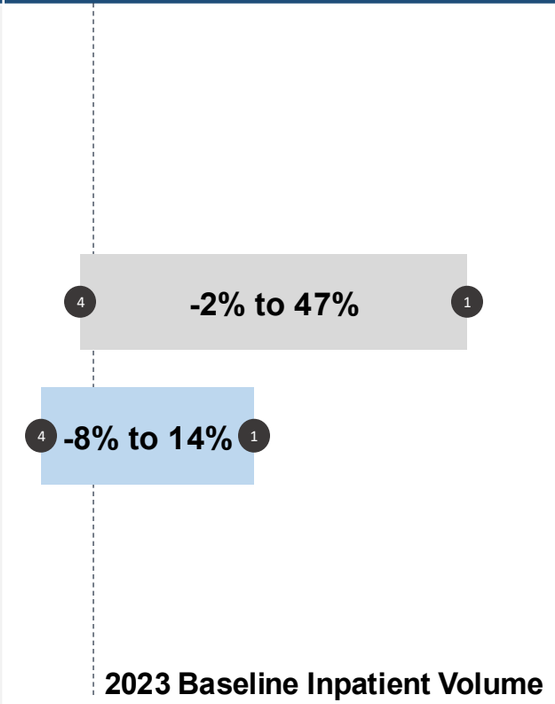


Financial/Operating

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

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

Key Assumptions: Inpatient Volume

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

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

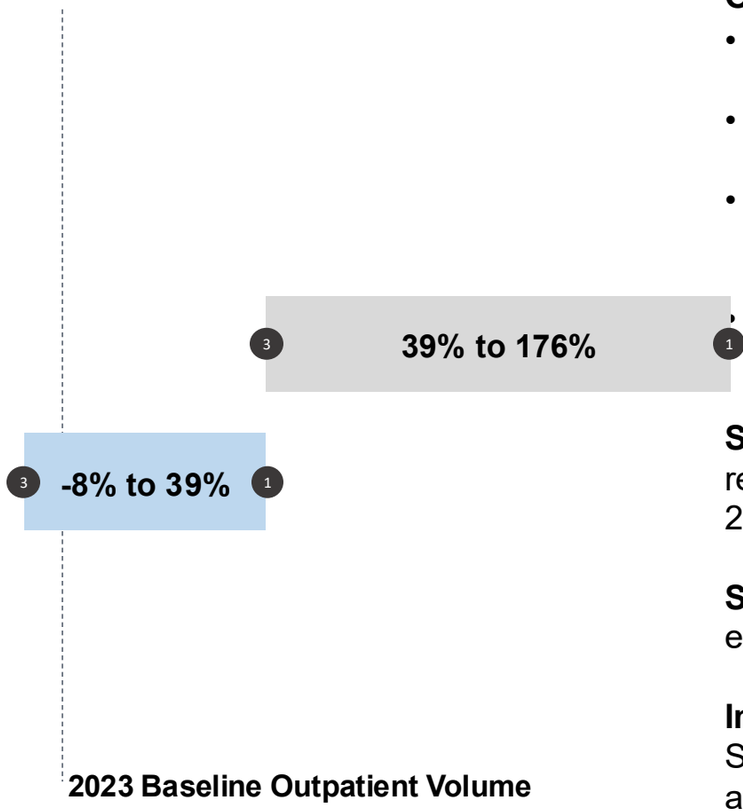
"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Outpatient Volume Growth

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

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

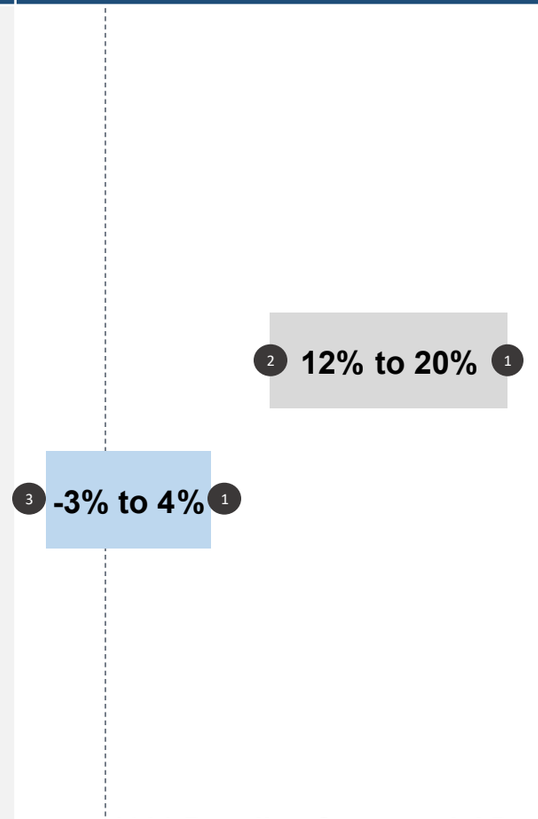
“What Must be True to Breakeven” Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Commercial Payer Mix

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

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

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Commercial Reimbursement

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

Medicare Reimbursement Rate

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

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Contribution Margin

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

2023 Baseline Contribution Margin

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

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumption: Overhead Cost Reduction

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

1. SUNY Downstate 2023 Cost Accounting Data

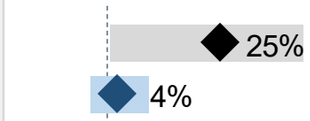
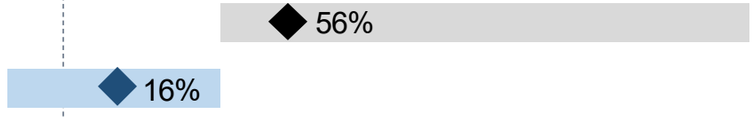
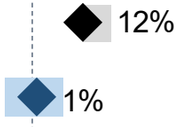
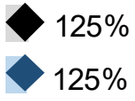
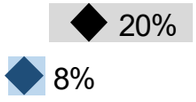
"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

DCAB Recommendation

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

2023 Baseline

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

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

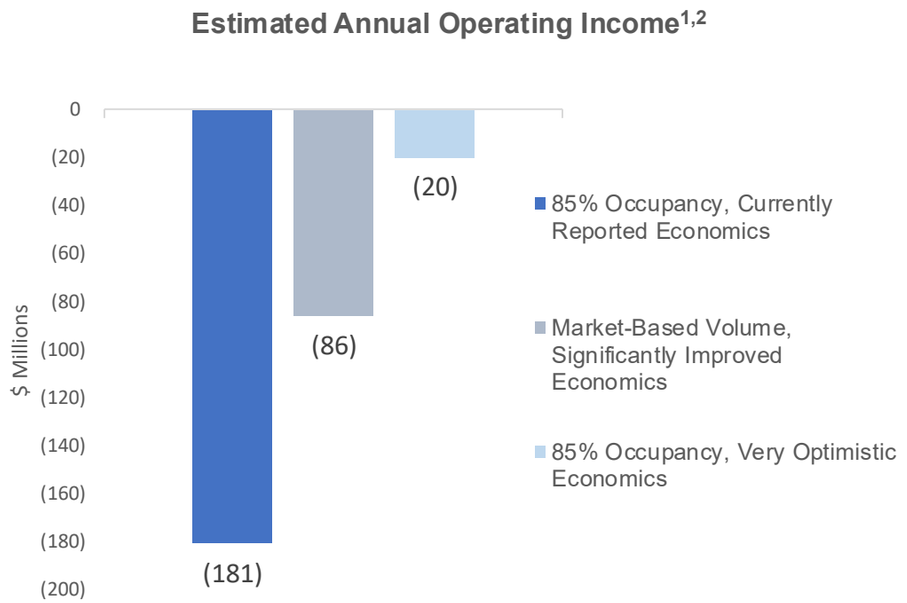
◆ Market-based Scenario-specific Assumption

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

DCAB Recommendation

Financial Implications



Key Takeaways

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

Implication: Ambulatory Focus Sustainably Aligns UHB to Community Needs

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

Concluded Range: ($181M) – ($20M)

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

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