Schedule 9
Project Financing

Contents:

Schedule 9 Proposed Plan for Project Financing:

I. Summary of Proposed Financial plan

Check all that apply and fill in corresponding amounts.

	Type	Amount
☐	A. Lease	$
☐	B. Cash	$2000
☐	C. Mortgage, Notes, or Bonds	$
☐	D. Land	$
☐	E. Other	$
☐	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$

If refinancing is used, please complete area below.

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

II. Details

A. Leases

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

B. Cash

Type	Amount
Accumulated Funds	$
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$2000
TOTAL CASH	$

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

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

C. Mortgage, Notes, or Bonds

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

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

D. Land

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

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

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

E. Other

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

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

F. Refinancing

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

Ira Davenport Memorial Hospital Administrative Review CON #241135

Cash for payment of the New York State Certificate of Need application came from the administrative operational budget.

The $2,000.00 application fee is the only cost associated with this project request.

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

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 43). Codes for completing this table are found in the Functional Codes Lookups sheet (see tab below).

Indicate if this project is: New Construction: NA OR Renovation: NA

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

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

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**0**	**0**	**0**	

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

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

	YES	NO
1. If New Construction is Involved, is it "freestanding?	☐	☐

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

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

SIGNATURE			DATE
Elizabeth Weir			3.1.24
PRINT NAME			TITLE
Elizabeth Weir			Site Administrator
NAME OF FIRM			
Ira Davenport Memorial Hospital			
STREET & NUMBER			
7571 State Route 54			
CITY	STATE	ZIP	PHONE NUMBER
Bath	NY	14810	607-776-8670

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

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 91).
Codes for completing this table are found in the Functional Code Lookups sheet (see tab below).

Indicate if this project is: New Construction: | | **OR** Renovation: | |

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

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

A		B	D	E	F	G	H	I
Location								
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Raw totals for whole project:					**0**	**0**	**0**	

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

Subtotals for Sub Project 1		0		
Subtotals for Sub Project 2		0		
Subtotals for Sub Project 3		0		
Subtotals for Sub Project 4		0		
Subtotals for Sub Project 5		0		
Subtotals for Sub Project 6		0		
Subtotals for Sub Project 7		0		
Subtotals for Sub Project 8		0		
Totals for Whole Project:	**0**	**0**	**0**	

1. If New Construction is Involved, is it "freestanding?	YES	NO
Sub Project 1		
Sub Project 2		
Sub Project 3		
Sub Project 4		
Sub Project 5		
Sub Project 6		
Sub Project 7		
Sub Project 8		
Totals for Whole Project:		

2. Check the box that best describe\s the location of the facilities affected by this	Dense Urban	Other metropolitan or suburban	Rural
Sub Project 1			
Sub Project 2			
Sub Project 3			
Sub Project 4			
Sub Project 5			
Sub Project 6			
Sub Project 7			
Sub Project 8			
Totals for Whole Project:			

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

SIGNATURE			DATE
PRINT NAME			TITLE
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE
This appendix lists the functional areas and services, beds and equipment, by facility type, which should be used in describing your proposals. In listing these services in the application, do not include any description inside parentheses.

HOSPITAL including Extension Clinics

Use the following listing for hospital proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
701	General Baseline Services (includes Anesthesia, Emergency Procedures, Nursing and Physician Services)
733	Baseline Clinical Laboratory Service
734	Baseline Dietetic
736	Baseline Medical/Surgical
741	Baseline Operating Room
742	Baseline Pharmaceutical Service
744	Baseline Recovery Room
	INPATIENT SERVICES
101	Acute Renal Dialysis
151	Alcohol Detoxification
152	Alcohol Rehabilitation
102	Ambulance
301	Audiology
201	Blood Services
103	Burn Center
104	Burn Program
203	Cardiac Catheterization - Adult
204	Cardiac Catheterization - Pediatric
205	Cardio-Pulmonary Function Analysis
206	Cleft Palate Center
105	Coronary Care
208	Cystoscopy
209	Dental
210	Diagnostic Radiology
153	Drug Detoxification
154	Drug Rehabilitation
106	Emergency Department
107	Intensive Care
213	Kidney Transplantation
214	Maternity
302	Medical Rehabilitation
108	Neonatal Continuing Care
109	Neonatal Intensive Care

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

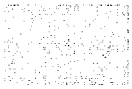
LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

110	Neonatal Intermediate Care
303	Occupational Therapy
215	Cardiac Surgery - Adult
216	Cardiac Surgery - Pediatric
356	Pathology Laboratory
218	Pediatric
111	Pediatric - ICU
304	Physical Therapy
112	Poison Control Center
221	Psychiatric
222	Psychiatric - Day/Night
230	Radioactive Materials - Diagnostic
231	Radioactive Materials - Therapeutic
224	Radioisotope Implantation
226	Respiratory Care
227	Respiratory Therapy
361	Self Care
362	Social Work Service
305	Speech-Language Pathology
228	Therapeutic Radiology
306	Vocational Rehabilitation
	OUTPATIENT SERVICES
491	Alcohol Rehabilitation O/P
402	Ambulatory Surgery
451	Audiology O/P
452	C.O.R.F.
423	Chronic Renal Dialysis O/P
406	Clinical Laboratory Service
407	Dental O/P
492	Drug Abuse Screening O/P
495	Drug Detoxification O/P
493	Drug Rehabilitation O/P
471	Family Planning O/P
472	Health Education O/P
473	Home Dialysis Training O/P
453	Medical Rehabilitation O/P
494	Methadone Maintenance O/P
413	Multiphasic Screening O/P
476	Nutritional O/P
454	Occupational Therapy O/P
414	Optometry O/P
425	Organized Outpatient Department
415	Outpatient Surgery
477	Part-Time Clinic(s)

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P
418	Prenatal O/P
419	Primary Medical Care O/P
420	Psychiatric O/P
421	Psychological O/P
424	Respiratory Therapy O/P
479	Social Work Service O/P
457	Speech-Language Pathology O/P
458	Vocational Rehabilitation O/P
	BED TYPE
151	Alcohol Detoxification
152	Alcohol Rehabilitation
103	Burns Care
105	Coronary Care
153	Drug Detoxification
154	Drug Rehabilitation
107	Intensive Care
214	Maternity
302	Medical Rehabilitation
701	Medical/Surgical
221	Psychiatric
108	Neonatal Continuing Care
109	Neonatal Intensive Care
110	Neonatal Intermediate Care
218	Pediatric
111	Pediatric ICU
220	Prisoner
226	Respiratory
361	Self Care
364	Special Use
	EQUIPMENT TYPE
423	Chronic Renal Dialysis Stations
501	CT Scanner
502	Cobalt Unit
503	Echo Cardiograph
504	Hyperbaric Chamber
505	Linear Accelerator
506	Megavoltage Unit
508	Ultrasound
601	Nuclear Magnetic Resonance Demonstration



New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

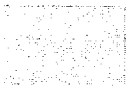
LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

RESIDENTIAL HEALTH CARE FACILITY
Use the following listing for Residential Health Care Facilities

Functional Codes	Service Description:
	BASELINE SERVICES
702	General Baseline Services - HRF's (includes Medical Services)
703	General Baseline Services - SNF's (includes Medical Services)
731	Baseline Activities Program
734	Baseline Dietetic
737	Baseline Nursing
742	Baseline Pharmaceutical Service
746	Baseline Social Work Service
	OPTIONAL SERVICES
301	Audology
352	Clinical Laboratory Service
209	Dental
210	Diagnostic Radiology
474	Non-Occupant Services
303	Occupational Therapy
217	Optometry
304	Physical Therapy
357	Physician Services
219	Podiatry
223	Psychological
359	Religious Services and Counseling
227	Respiratory Therapy
305	Speech-Language Pathology
	BED TYPES
703	SRF
	EQUIPMENT TYPES
501	CT Scanner
503	ECHO Cardiograph
508	Ultrasound

DIAGNOSTIC AND TREATMENT CENTER including Extension Clinics
Use the following listing for Diagnostic and Treatment Center proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
704	General Baseline (Includes Medical Staff)



New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

	OPTIONAL SERVICES
401	Abortion O/P
491	Alcohol Rehabilitation O/P
402	Ambulatory Surgery
451	Audiology O/P
406	Clinical Laboratory Service
452	C.O.R.F.
423	Chronic Renal Dialysis O/P
407	Dental O/P
408	Diagnostic Radiology O/P
492	Drug Abuse Screening O/P
495	Drug Detoxification O/P
493	Drug Rehabilitation O/P
471	Family Planning O/P
472	Health Education O/P
473	Home Dialysis Training O/P
453	Medical Rehabilitation O/P
494	Methadone Maintenance O/P
413	Multiphasic Screening O/P
475	Nursing O/P
476	Nutritional O/P
454	Occupational Therapy O/P
414	Optometry O/P
477	Part-Time Clinic(s)
416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P
418	Prenatal O/P
419	Primary Medical Care O/P
420	Psychiatric O/P
421	Psychological O/P
479	Social Work Service O/P
457	Speech-Language Pathology O/P
427	Therapeutic Radiology O/P
	EQUIPMENT
423	Chronic Renal Dialysis Stations
502	Cobalt Unit
501	CT Scanner
503	Echo Cardiograph
505	Linear Accelerator
506	Megavoltage Unit
508	Ultrasound

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

MIDWIFERY BIRTH CENTER including Extension Clinics
Use the following listing for Midwifery Birth Center proposals:

Functional Codes	Service Description:
416	Pediatric O/P
418	Prenatal O/P
419	Primary Medical Care O/P

HOME HEALTH AGENCY
Use the following listing for Home Health Agency proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
705	General Baseline (includes Home Health Aide and Medical Supplies, Equipment and Appliances)
738	Baseline Nursing (Contract)
739	Baseline Nursing (Direct)
	OPTIONAL SERVICES
481	Medical Social Services O/P
476	Nutritional O/P
454	Occupational Therapy O/P
455	Physical Therapy O/P
482	Personal Care
483	Physicians Services
424	Respiratory Therapy
457	Speech-Language Pathology O/P

LONG-TERM HOME HEALTH CARE PROGRAM
Use the following listing for Long-Term Home Health Care Program Proposals

Functional Codes	Service Description:
	BASELINE SERVICES
707	General Baseline Services (includes Audiology; Home Health Aide; Homemaker, Housekeeper; Medical Social Work; Medical Supplies; Equipment And Appliances; Nutritional; Occupational Therapy; Personal Care; Physical Therapy; Respiratory Therapy; and Speech-L
738	Baseline Nursing (Contract)
739	Baseline Nursing (Direct)
	OPTIONAL SERVICES
357	Physician Services

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

	PATIENT CAPACITY
707	Designated patient capacity

HOSPICE

Use the following listing for Hospice Proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
706	General Baseline Services (includes Bereavement, Home Health Aide, Homemaker, Housekeeper, Nursing, Medical Supplies, Equipment & Appliances, Nutritional, Pastoral Care, Personal Care, Physician Services and Psychological)
732	Baseline Audiology
733	Baseline Clinical Laboratory Service
735	Baseline Inpatient Services
740	Baseline Occupational Therapy
742	Baseline Pharmaceutical Service
743	Baseline Physical Therapy
745	Baseline Respiratory Therapy
746	Baseline Social Work Service
747	Baseline Speech-Language Pathology
	BEDS
706	Hospice beds

NON-MEDICAL FUNCTIONAL AREAS

Use these codes for all health care facilities to describe non-medical functional areas:

Functional Codes	Service Description:
	NON-MEDICAL SERVICES
901	Administration (Routine)
902	General Administration
903	Admitting
904	Accounting/Financial Service
905	Administrative Personnel
906	Data Processing
907	Fund Appeal/Volunteers
908	Medical/Social Services
909	Energy Proposal
910	Telephone System
920	Public Areas
921	Cafeteria
922	Chapel/Meditation
923	Lobby/Waiting/Public Entrance
924	Coffee/Gift Shop/Flower/Canteen/Snack Bar

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

930	Education/Research
931	Supervising Physicians' Offices (Hospital Physicians involved in
932	Nursing School
933	Medical Laboratory/Auditorium
934	Research (Laboratory areas)
935	Medical Teaching (for residents and interns; Classrooms)
940	Industrial/Service Functions
941	Central Sterile and Supply
942	Laundry/Linen
943	Maintenance/Housekeeping
944	Medical Supplies/Central Services/Storage
945	Parking Structures (free-standing structures)
946	Staff Lockers
947	Tunnels, Bridges and Other Enclosed Circulation Spaces
948	Equipment Maintenance (includes Biomedical Engineering Service)
960	Building System
961	Site Work (Replant grass, signs, etc.)
962	On-site Parking, Excluding Garage Structure (parking lot)
963	Outside Utilities (water, sprinkler, lights, Outside sewer, etc.)
964	Structure, Including Finisher (Paint building, etc.)
965	Heating/Ventilation/Air Conditioning (HVAC)
966	Sanitary System (Inner plumbing and ventilation)
967	Electrical System
968	Vertical & Horizontal Mechanized Movement (elevators, cart system)
980	Other Functions
981	Private Physicians Offices
982	Housing on Call (Interns, residents, physicians)
983	Housing Other (for parents of young patients, visitors, etc.)
984	Medically Related Computer

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

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
		NA				

Total lease and purchase costs: Subproject 1	
Total lease and purchase costs: Subproject 2	
Total lease and purchase costs: Subproject 3	
Total lease and purchase costs: Subproject 4	
Total lease and purchase costs: Subproject 5	
Total lease and purchase costs: Subproject 6	
Total lease and purchase costs: Subproject 7	
Total lease and purchase costs: Subproject 8	
Total lease and purchase costs: Whole Project:	0

New York State Department of Health
Certificate of Need Application
Schedule 11 - Moveable Equipment

Table 2 - Equipment being replaced:

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

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Disposition	Estimated Current Value
		NA			
				Total estimated value of equipment being replaced: Subproject 1	
				Total estimated value of equipment being replaced: Subproject 2	
				Total estimated value of equipment being replaced: Subproject 3	
				Total estimated value of equipment being replaced: Subproject 4	
				Total estimated value of equipment being replaced: Subproject 5	
				Total estimated value of equipment being replaced: Subproject 6	
				Total estimated value of equipment being replaced: Subproject 7	
				Total estimated value of equipment being replaced: Subproject 8	
				Total estimated value of equipment being replaced: Whole Project:	0