NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Capital Rate Appeal Information

Providers are required to submit the following:				
1	Cover letter providing the details of the request, signed by the provider's CEO/CFO and addressed to =>	**Monique Grimm** **Director** **Bureau of Hospital & Clinic Rate Setting** **One Commerce Plaza, Room 1432** **99 Washington Avenue** **Albany, New York 12210**		
2	Copy of the Certificate of Need (CON) approval letter issued by the Division of Health Facility Planning. For copies or questions email: cons@health.ny.gov			
3	Copy of the project completion and building occupancy letter issued by the regional Department of Health office after the site visit.			
4	Annual Visits / Procedures projected as part of the Certificate of Need (CON) process		**Total Annual Visits**	**Total Annual Medicaid Fee-for-Service Visits**
5	Itemized details of the Total CON-approved capital costs. ***Note : Complete all applicable information. All items may NOT apply to your facility.***			

		CON Approved Capital Costs ($ Value)	**Useful Life of the Asset**	**Depreciation / Amortization per Year**
a.	Rent (if the building is leased)			
b.	Building			
c.	Renovation & Demolition			
d.	Construction Contingency			
e.	Architect / Engineering Fees			
f.	Other Fees			
g.	Moveable Equipment			
h.	Financing Costs			
i.	Interim Interest Expense			
j.	CON Fees			
	Total Project Cost approved per the CON application	**$0**		**$0**