NEW YORK BUILDING CONGRESS

New York Building Foundation

BUILDING A HEALTHIER FIVE BOROUGHS

THE INFRASTRUCTURE BEHIND BETTER HEALTH AND ECONOMIC GROWTH

A New York Building Congress Healthcare and Life Sciences Report

2026 HEALTHCARE AND LIFE SCIENCES REPORT

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A MESSAGE FROM OUR CHAIR, AND PRESIDENT & CEO

BUILDING THE NEXT GENERATION OF HEALTHCARE & LIFE SCIENCES IN NEW YORK

New York's healthcare sector is one of the great strengths of our city. It powers local economies, creates jobs, and most importantly, it heals us when we're sick. From major hospital campuses to neighborhood-level medical offices, healthcare facilities are a vital part of the city's infrastructure.

People travel from far and wide to come to New York's prestigious healthcare institutions, because they know the level of care is top notch. Let's keep it that way.

Healthcare is changing, and the spaces that support care need to grow and change as well. New technologies, modern building systems, evolving models of care, and the growing need for community-based services all require facilities that can adapt alongside the needs of patients and providers. We must keep pace with modern medicine and provide healthcare professionals with the environments they need to deliver excellent care.

New York City should make that work easier.

Too often, projects that would improve access and support modernization face avoidable land use hurdles, uncertainty, and delay that slows investment and makes it harder to deliver the kinds of healthcare spaces a dynamic, growing city needs. When the public benefit is this clear, the path forward should be clear too.

New York already understands this problem. The State's SEQRA reform push makes the point clearly: simpler environmental review, clearer timelines, and more predictable approvals can lower housing costs while preserving core environmental safeguards. The City has moved in the same direction through "Get Stuff Built" and the Mayor's SPEED Task Force, both focused on cutting permitting barriers that make housing and infrastructure harder to deliver. Healthcare should be next.

New York has already shown that it can modernize rules when the need is apparent. We have seen smart progress through recent zoning reforms that opened new opportunities for housing, and life sciences. That same practical approach should also be applied to other healthcare facility types. Hospitals, outpatient centers, and other essential care settings deserve a framework that reflects how healthcare is delivered today.

This report makes a simple case: healthcare construction is essential infrastructure, and the modernization of existing hospitals is not optional. It deserves a regulatory process that is predictable, efficient, and aligned with the public good. By reducing unnecessary red tape and creating a more practical modernization pathway, New York can support even better access to care.

The healthcare industry is ready to lead. The building industry is ready to build. New York should be ready to act.

Cheryl McKissack Daniel
Chair, New York Building Congress
Chair of the Board
McKissack & McKissack

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President & CEO
New York Building Congress

BACKGROUND AND SUMMARY

New York City's healthcare sector remains one of the city's largest and most important economic engines, and a major part of its physical infrastructure. Responsible for over 7% of the city's GDP, "Health Care & Social Assistance" accounted for 1,016,400 jobs in New York City as of January 2026. Life sciences accounts for 18,800 jobs and over $7 billion in GDP. The New York City Comptroller's office also reported that "Health Care & Social Assistance" was the city's primary job creator over the 12 months ending in December 2025. The average salary for hospital workers stands at $116,800 per year.[1] [2] [3] There is also an important equity component to these jobs, as hospitals operate in all five boroughs, serving and employing people from diverse communities throughout the entire city.

The sector's economic footprint is substantial. Even looking only at hospitals and health systems, the impact in New York City is enormous. A 2025 regional analysis by the Healthcare Association of New York State found that New York City hospitals and health systems generate over $123 billion in annual economic activity and generate over $21 billion in tax dollars. The same analysis found that each year, these institutions provide roughly 23 million outpatient visits, treat 4.1 million people in emergency rooms, and admit 1.1 million patients.[4] Hospitals are also major civic institutions whose value extends well beyond the walls of their campuses. A 2026 Greater New York Hospital Association (GNYHA) analysis found that New York City not-for-profit hospitals provided $9.5 billion in community benefits in 2023. Those benefits include financial assistance, community health services, research, professional education, and a variety of subsidized health services.[5]

A SECTOR DEFINED BY NECESSITY

The form and structure of a modern healthcare facility is often determined by strict regulatory codes and standards. Thus, the size and shape of a new hospital, for example, is not actually subject to much discretion.

Similar to infrastructure projects that would reinforce the structural integrity of an old bridge, where delayed capital spending often leads to ballooning costs and emergency repair work, healthcare facility modernization projects are required, essential infrastructure upgrades. Hospitals built in 1957 cannot deliver 2026 care in 1957 space. The work of upgrading them is required, not optional, and it is critical for the city's public health.

DISTRIBUTED CARE

The industry is also changing in ways that make flexibility more important. More care is moving closer to where people live and work, through outpatient centers, ambulatory care, diagnostics, and behavioral health facilities. This distributed care model can improve convenience and efficiency by moving less urgent care out of the hospital setting.

But shifting that care elsewhere does not simply eliminate the need for space within hospitals. As lower-acuity care moves into outpatient and ambulatory settings, hospitals are increasingly focused on the most urgent, complex, and resource-intensive cases. Those cases require major investment in physical space, including larger and more advanced operating rooms, intensive care capacity, and many other specialized areas. The distribution of routine care directly increases infrastructure-related intensity of what remains in the hospital.

While new types of facilities are expanding, hospital facilities that anchor this care still need continuous modernization to ensure that the best care is available to the most people.

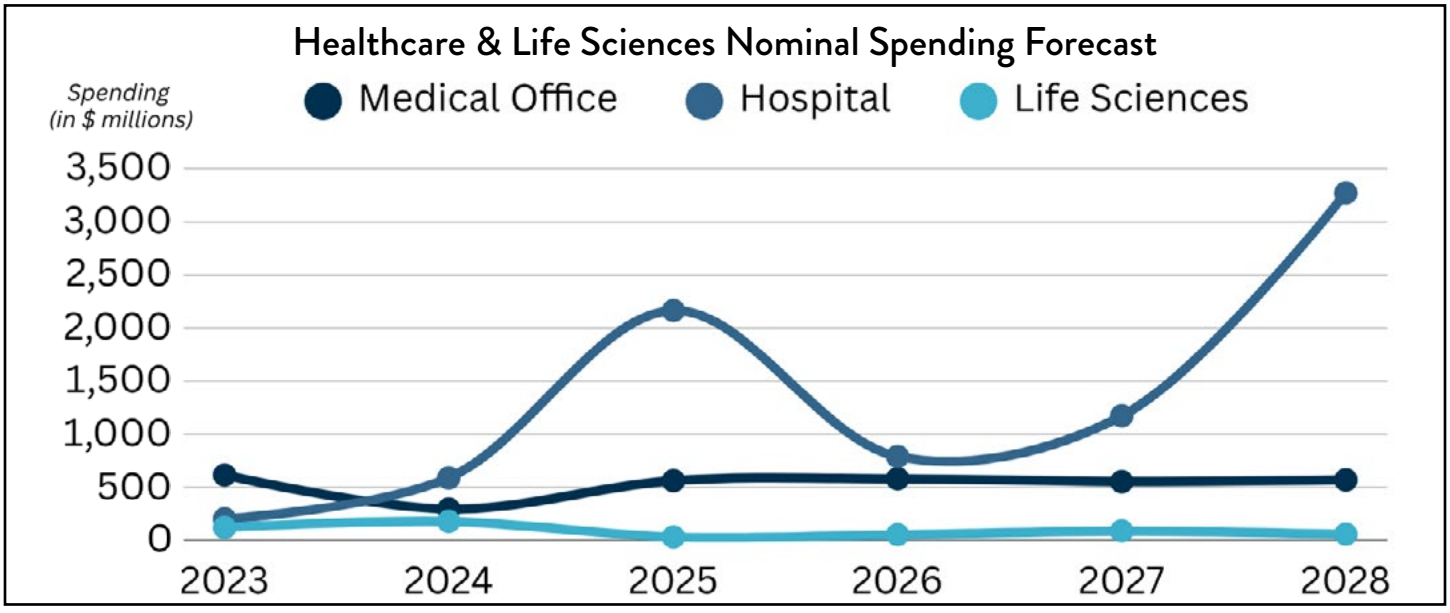
1 https://edc.nyc/sites/default/files/2026-04/NYCEDCww-NYC-Economic-Snapshot-April-2026.pdf
2 https://comptroller.nyc.gov/wp-content/uploads/2026/02/New-York-by-the-Numbers-February-2026.pdf
3 https://edc.nyc/sites/default/files/2026-02/NYCEDC-2025-State-of-NYC-Economy_2-12-2026.pdf
4 https://www.hanys.org/government_affairs/community_benefit/docs/region/new_york_city.pdf
5 https://www.gnyha.org/wp-content/uploads/2026/03/GNYHA-Community-Benefit-Reports-TY2023.pdf

This impact matters for the construction pipeline as well. The Building Congress's 2025-2027 Construction Outlook report identified healthcare as one of the sectors posting the largest year-over-year growth in 2025 and we project continued growth for major new projects and redevelopment work through 2027. Healthcare construction is a large share of the entire construction industry within New York City, consistently driving new projects, and creating good-paying construction jobs year over year.[6] [7] [8]

Below is a forecast of the expected spending across the healthcare sector within New York City over the next three years.

Nominal Dollars	Actual Spending			Projected Spending		
	2023	2024	2025	2026	2027	2028
Medical Office	616,221,843	294,665,555	562,048,457	580,115,427	553,028,734	568,935,100
Hospital	202,475,245	588,257,866	2,165,070,182	790,849,284	1,172,146,752	3,273,442,461
Life Sciences	121,649,814	178,615,137	31,407,442	52,441,000	87,487,860	57,112,101
Total	**940,346,902**	**1,061,538,558**	**2,758,526,081**	**1,423,405,711**	**1,812,663,346**	**3,899,489,661**

Inflation Adjusted	Actual Spending			Projected Spending		
	2023	2024	2025	2026	2027	2028
Medical Office	785,593,960	385,367,238	694,066,887	580,115,427	526,694,033	516,040,907
Hospital	258,126,730	769,330,874	2,673,619,155	790,849,284	1,116,330,240	2,969,108,808
Life Sciences	155,085,965	233,595,074	38,784,673	52,441,000	83,321,771	51,802,359
Total	**1,198,806,655**	**1,388,293,186**	**3,406,470,715**	**1,423,405,711**	**1,726,346,044**	**3,536,952,074**



6 https://nycfuture.org/research/caution-ahead

7 https://www.nychealthandhospitals.org/pressrelease/an-historic-day-for-south-brooklyn-ruth-bader-ginsburg-hospital-opens-for-care-welcomes-first-patients-opens-new-emergency-department/

8 https://www.nychealthandhospitals.org/pressrelease/elmhurst-announces-plans-for-emergency-department-expansion/

Some notable upcoming projects include:

THE KENNETH C. GRIFFIN PAVILION
Memorial Sloan Kettering Cancer Center | New York, NY

Photo Credit: https://www.griffincatalyst.org/newsroom/cancer-center-future-kenneth-griffin-pavilion-memorial-sloan-kettering/

The Kenneth C. Griffin Pavilion at Memorial Sloan Kettering Cancer Center which will be a new 27-story, LEED-certified cancer care pavilion designed to support advanced technology, robotics, digital infrastructure, and upgraded operating and procedure suites. The project is expected to be completed in 2030 and will connect to Memorial Hospital through a two-story pedestrian bridge over East 67th Street.

New York Building Congress Members involved:
CannonDesign, LERA Consulting Structural Engineers, Memorial Sloan Kettering Cancer Center, Trinity/JB&B, Turner-Consigli JV, VHB

VICTORIA AND LLOYD GOLDMAN HEALTH CARE PAVILION
Northwell Health and Lenox Hill Hospital | New York, NY

Photo Credit: Northwell Health

The **Victoria and Lloyd Goldman Health Care Pavilion** will be a new 15-story, 200,000 sf outpatient facility for Northwell Health and Lenox Hill Hospital. Located on Third Avenue between East 76th and 77th Streets, the $450 million project is expected to be completed in 2027 and will include Outpatient Services (Cardiac, Neurology/Neurosurgery, Pulmonary, Urology), Oncology Services (Breast, Hemotologic, Gynocologic, Infusion, Medical, Radiation, Surgical), Endoscopy, Interventional Radiology along with Advanced Imaging Services.

New York Building Congress Members involved:
Consigli Construction Co., Inc., Ennead Architects, Northwell Health, Severud Associates, Trinity/JB&B, VHB

THE MOUNT SINAI TISCH CANCER HOSPITAL
Mount Sinai's Upper East Side Campus | New York, NY

Photo Credit: Kohn Pedersen Fox

The Mount Sinai Tisch Cancer Hospital is an anticipated 200,000 sf renovation project on Mount Sinai's Upper East Side campus. The $205 million adaptive reuse project renovates existing construction, replaces the façade, and adds a new connecting core to consolidate cancer inpatient care in a contemporary clinical environment. Construction is anticipated to begin in 2026 and includes phased construction to coordinate with continuous hospital operations.

New York Building Congress Members involved:
AKF Group, Gilbane, HKS, KPF, Mount Sinai Hospital, Severud Associates, VHB, WSP

MODERN CARE IN OLDER BUILDINGS:
WHY MODERNIZATION NEEDS MORE SPACE

New York City's healthcare system operates in a dense, mature urban environment where many facilities have been expanded, adapted, and modernized over time to meet changing needs. This work is essential, and too often, prohibitively expensive. A 2022 joint hospital association survey reported that 77% of hospitals are delaying or cancelling capital improvement projects due to fiscal challenges.[9] In recognition of soaring costs, in 2025, the NY Department of Health raised the Full Review threshold for general hospital projects from $30 million to the greater of $60 million or 10% of operating costs, capped at $150 million.[10] [11]

The modernization challenge also reaches the city's safety net hospitals directly. The Center for an Urban Future found in 2014 that New York City's public hospital buildings were, on average, built in 1957. Since then, Health + Hospitals has delivered some important modernization projects, notably the $923 million Ruth Bader Ginsburg Hospital (largely funded by FEMA) at South Brooklyn Health, which opened in 2023 with private patient rooms and a whole slew of modern services. Elmhurst Hospital has also advanced a $43 million emergency department expansion. These projects show real progress. They also highlight the scale of the work still needed across an aging safety net system that serves many of the city's highest-need communities. Any modernization framework needs to work for these facilities too, especially when older buildings, constrained capital budgets, and urgent community health needs make delays even harder to absorb.

These projects are complex and expensive for a simple reason: A hospital cannot close to renovate. Modernization often means building inside an active clinical environment, where emergency care and critical life-support systems must keep running while construction is staged around patient care. That reality makes hospital projects longer, more expensive per square foot, and more logistically demanding than comparable work in other building types. Even modest renovations can take years because the work must move in carefully sequenced phases around the hospital's daily operations. Added building area is often necessary to keep services running and shorten the disruption, giving hospitals room to modernize without forcing care to stop. This is no easy task.

Photo Credit: https://nsuh.northwell.edu/

As healthcare organizations address deferred maintenance and expand facilities to support more specialized care, delivering complex upgrades in active hospital environments without disrupting operations has become increasingly critical. This work demands meticulous coordination, rigorous infection-control protocols, and constant attention to air quality, noise, vibration, and safety.

During construction of Northwell's North Shore University Hospital Advanced Surgical Pavilion in Manhasset, New York, the Skanska team preserved sterile conditions by implementing a pressurized tunnel system and integrating positive and negative air pressure controls between the new pavilion and the existing hospital. These measures prevented dust, fumes, and odors from entering active hospital operations while also mitigating noise and vibration. By carefully sequencing work around ongoing operations, the team delivered modern surgical and critical-care spaces while allowing Northwell to continue providing exceptional care to Long Island patients.

Sean Szatkowski
Executive Vice President – General Manager, Skanska USA Building

9 https://www.gnyha.org/wp-content/uploads/2023/07/2022_critical_condition_report.pdf
10 https://www.health.ny.gov/facilities/cons/docs/nycrr_710-1_guidance.pdf
11 https://dos.ny.gov/system/files/documents/2025/08/080625.pdf

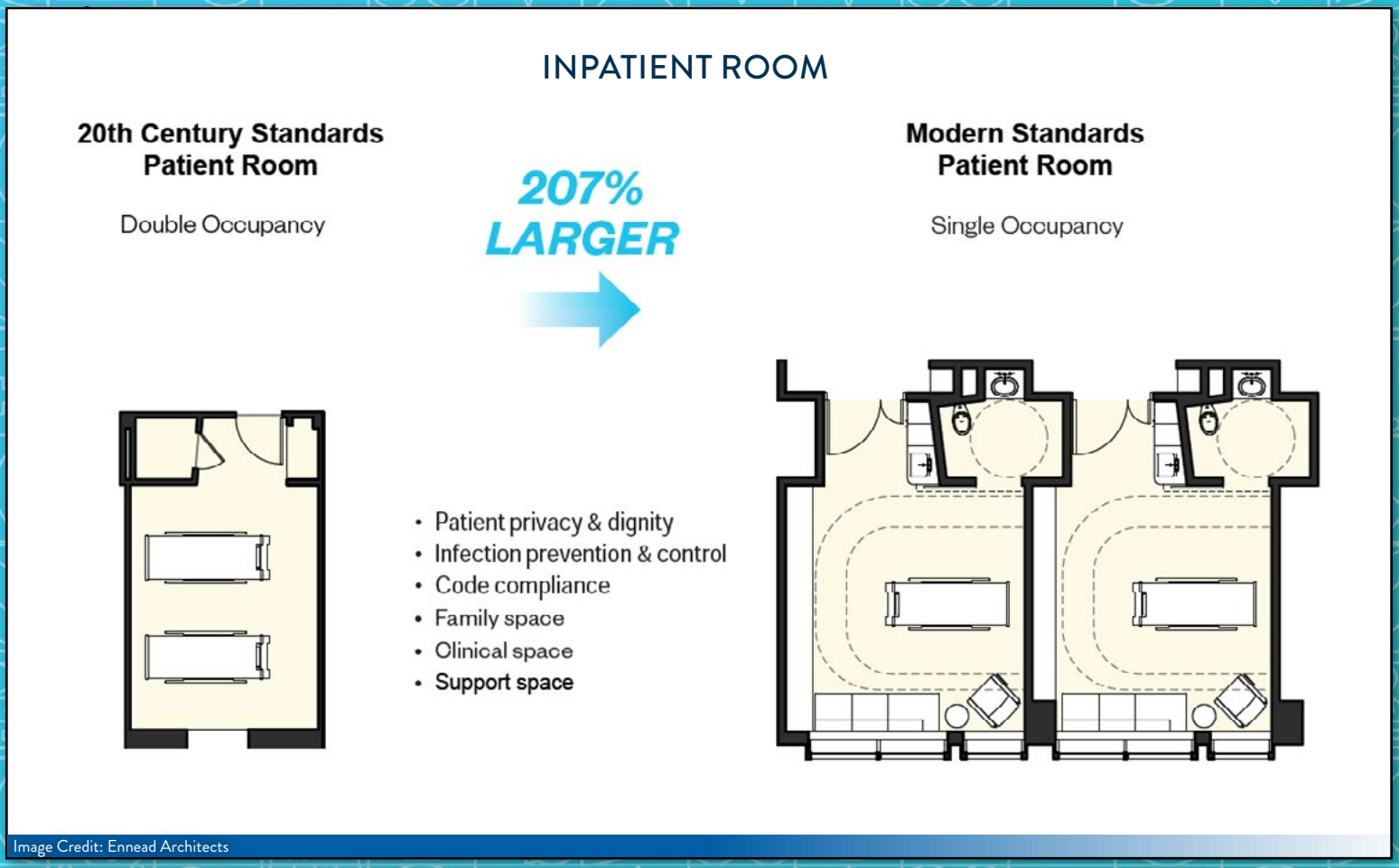
WHY DO HOSPITALS NEED MORE SPACE THAN THEY USED TO?

New York State requires healthcare facilities to comply with healthcare-specific construction, engineering, and design standards. That's because modernization is shaped by healthcare-specific necessities tied to clinical use, life safety, infection prevention, privacy, and many other factors. All of these have implications for new spatial needs.

Let's look at some examples:

SINGLE-BED PATIENT ROOMS

Basic core hospital design requirements have evolved throughout the years. One of the clearest examples of modernization-driven growth is the shift toward single-bed patient rooms. Under the 2010 Facility Guidelines Institute (FGI) Guidelines, which New York incorporated into its construction standards for newer general hospital projects, medical/surgical patient rooms are generally limited to one bed (unless the facility can demonstrate the need for a two-bed arrangement and receives special approval). The same standards require at least 120 square feet for a single-bed patient room, along with a restroom. 60 years ago, patient rooms could hold 4 beds, with one shared restroom. Prior to the more recent shift to single-bed inpatient rooms, a double-bedded arrangement was typical. Replacing a 20th-century double-occupancy room with two single-occupancy rooms meeting current standards results in a room cluster that is significantly larger than its predecessor, and this change alone is one of the leading factors explaining why modernization requires more space even when the number of beds does not materially grow. Patient rooms also require windows, which drives building heights



OPERATING ROOMS

Operating rooms have undergone a similar transformation. Growth is specifically driven by three forces operating in combination: (1) increased clearances and code-mandated minimums, (2) larger surgical care teams and the integration of equipment and control rooms within or adjacent to the OR, and (3) image-guided procedures, surgical robotics, and hybrid operating rooms that integrate intraoperative imaging.

Under the older NYS Hospital Code, which applies to general hospital facilities approved before 1998, each inpatient operating room had to be at least 270 square feet. Support space was required, but it was flexible, based on expected surgical workloads. For newer projects, the State moved to a more detailed standard. As of 2010, the state requires that a standard operating room must be at least 400 square feet, with more complex specialty operating rooms at 600 square feet. Support spaces are also much more prescriptive and now carry hard sizing requirements, such as the requirement for equipment and supply storage rooms to be "not less than 300 square feet or 50 square feet per operating room, whichever is greater." [12] [13] So, newer standards specifically require larger operating rooms, and larger areas around those rooms to support them.

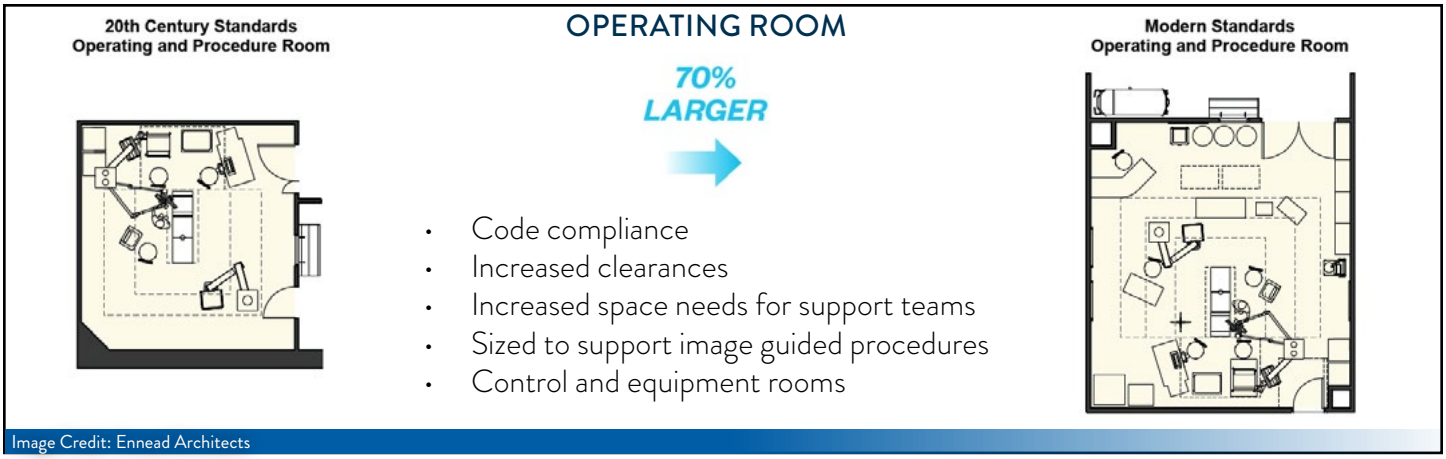


Image Credit: Ennead Architects

CATHOLIC HEALTH
Mercy Hospital Emergency Department | Rockville Centre, NY

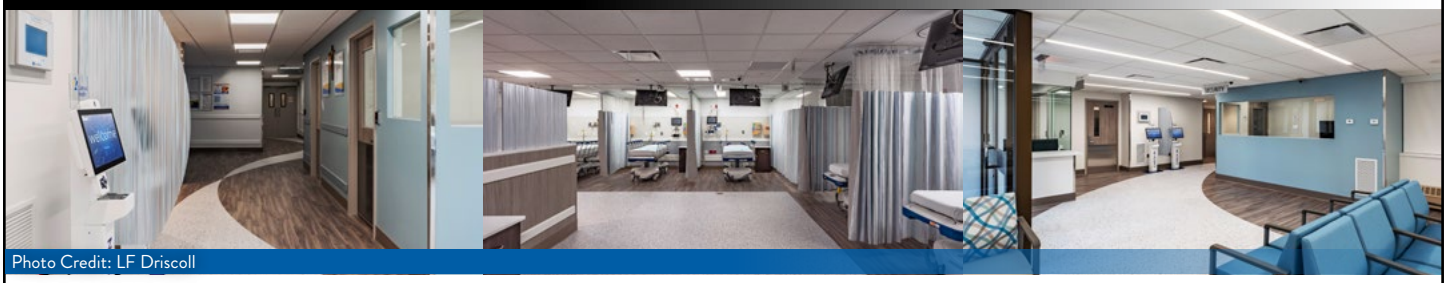


Photo Credit: LF Driscoll

Smaller modernization projects show the same basic challenge at a different scale. Catholic Health's Mercy Hospital Emergency Department expansion in Rockville Centre was a 9,500-square-foot renovation and fit-out completed in June 2024, serving eastern New York City and western Nassau County. The $4 million project added or upgraded 29 patient bays, a nurses' station, a cardio trauma room, radiology, triage, and related emergency department space.

Healthcare construction requires careful planning even when the physical footprint is modest. Mercy's ED work was first planned across nine phases and two projects, with three phases requiring NYS Department of Health filings. The team later restructured the sequence to account for long-lead materials, maintain momentum, and keep work moving in an active emergency department. That kind of coordination and phasing is often what makes modernization possible without disrupting patient care.

New York Building Congress Member involved: LF Driscoll

12 New York State Department of Health, Standards of Construction for Health Care Facilities, adopted regulations, 10 NYCRR Parts 711–715

13 https://fgiguidelines.org/wp-content/uploads/2022/03/2010_FGI_Guidelines.pdf

HVAC AND MEP STANDARDS

Other, often unseen requirements of healthcare spaces have also become more complex. HVAC and MEP standards that New York incorporated into its hospital construction rules address temperature, humidity, hot water demand, and airflow, all designed for specific healthcare needs. For example, as our understanding of disease prevention has continuously advanced, our expectations around infection prevention, patient placement, and ventilation have changed significantly. American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standard 170 requires hospital-grade ventilation that maintains different pressure relationships across clinical spaces.[14] These have surpassed what many facilities were originally designed around.

Consider something like an airborne infection isolation area. The Centers for Disease Control and Prevention's (CDC) guidance for airborne infection isolation areas requires single-occupancy rooms, negative pressure, improved ventilation and exhaust, and higher air-change rates. This means heavier-duty machinery to pump air in and out, space to store the equipment, and adequate room for more robust ventilation and exhaust requirements. New shafts, new ducts, new filtration systems, new plumbing networks, and new room configurations. With upgraded technology it also means dedicated areas for system controls and support functions. All of that involves allocating considerable amounts of space. In older buildings, fitting those requirements into an existing envelope can be particularly challenging.[15]

These requirements affect building volume and height as well as floor area. Modern hospitals need room above ceilings, between floors, and in protected equipment areas for ventilation, power, plumbing, controls, and other critical systems.

ENERGY

Hospitals are among the most energy-intensive building types in the city. As hospitals rely more heavily on technology, equipment, and machinery, modern healthcare facilities need stronger backup energy systems to minimize disruptions to patient care. Because hospitals are highly energy-intensive, many also rely on large central plants and built-in redundancies to maintain resiliency. No one wants the lights to go out during surgery. Hospitals must also continue to operate through conditions that would shut down most other buildings. That obligation requires real building and campus space for the backup energy and resilient utility systems that keep essential care running during major disruptions. Modern hospitals increasingly include cogeneration capacity, which allows a hospital to generate its own electricity and capture waste heat for facility use. Cogeneration allows a hospital to operate independently of the utility grid during a power outage.[16] Hospitals need the physical space to house these systems.

The table below compares 5 basic spatial expectations, now commonplace today, compared with the federal minimum standards used approximately 60 years ago.[17] [18] [19] [20]

Feature	Current Expectation / Standard	1967 Federal Minimum Standard
Patient Rooms	Single-bed rooms: at least 120 square feet, with in-room handwashing and restroom.	Patient rooms could hold up to four beds at 80 square feet per bed.
Operating Rooms	Minimum 400 sf (standard) or 600 sf (specialty); prescriptive support space requiements	Minimum 270 sf; flexible support based on expected workloads
Burn Trauma ICU	Burn trauma ICU rooms must function as protective environment rooms, and have ready OR access.	No dedicated burn-trauma ICU room requirements.
Imaging	MRI equipment and advanced imaging requires specialized, dedicated spaces. Patient waiting areas are now required.	MRI machines did not yet exist.
Telemedicine	Telemedicine includes standards to ensure privacy.	Telemedicine did not yet exist.
Infection Control	Sealed single-bed rooms, restroom, storage areas, self-closing doors, and HVAC controls.	One per 30 beds, lavatory, window, and an anteroom with aseptic facilities.

14 https://www.ashrae.org/technical-resources/standards-and-guidelines/standards-addenda/ansi-ashrae-ashe-standard-170-2017-ventilation-of-health-care-facilities
15 https://www.cdc.gov/infection-control/hcp/environmental-control/recommendations.html
16 NFPA 110, Standard for Emergency and Standby Power Systems; NFPA 99, Health Care Facilities Code; CMS Conditions of Participation, 42 CFR § 482.41(d).
17 https://www.health.ny.gov/facilities/cons/docs/article_28_reference_standards.pdf
18 United States Public Health Service, General Standards of Construction and Equipment for Hospital and Medical Facilities, Public Health Service Publication No. 930-A-7, U.S. Government Printing Office, 1967
19 https://fgiguidelines.org/wp-content/uploads/2022/03/2010_FGI_Guidelines.pdf
20 https://fgiguidelines.org/wp-content/uploads/2022/10/2022-Hosp-Major-additions-and-revisions.pdf

RESILIENCY

Hurricane Sandy in October 2012 changed the standard for hospital resiliency in New York. Critical mechanical and electrical infrastructure can no longer be located at or below grade in flood-prone areas. Perimeter flood barriers, elevated equipment, sealed exterior penetrations, internal flood doors, and backflow preventers are now standard features of any responsible hospital design in coastal Manhattan and the broader metro region. Many new hospital builds during the post-Sandy period were funded by FEMA grants.

CASE STUDY: NYU LANGONE HEALTH
MANHATTAN MAIN CAMPUS | New York, NY

Photo Credit: Jeff Goldberg/Esto

NYU Langone Health's main campus on First Avenue sits along the East River on a site that proved highly vulnerable to storm surge during Hurricane Sandy in October 2012. The flooding caused extensive damage to mechanical and electrical infrastructure across the campus, prompting NYC Langone to modify the campus transformation that was already underway, and integrating new requirements to protect the campus from future climate conditions.

The transformation involved three coordinated moves:

- Relocation of campus mechanical and electrical infrastructure from below grade to the first floor and above.
- Construction of the Energy Building (2016), housing a cogeneration plant and emergency power capacity that allows the main campus to operate independently of the utility grid when needed.
- Construction of the Science Building (2018), a 365,000-square-foot, 16-story modern research facility designed to bring research activity closer to the clinical environment.
- Construction of the Kimmel Pavilion (2018), an 830,000-square-foot, 21-story clinical tower with 374 single-occupancy patient rooms and an expanded procedural platform.

The Kimmel Pavilion was delivered without a net increase in total licensed beds for NYU Langone's First Avenue campus. It replaced the Rusk Institute Building, opened in 1949, and augmented the adjacent Tisch Hospital, opened in 1963, with resilient, code-compliant, modern facilities. The campus now has substantially more space for patients and procedures, supported by the mechanical and resiliency infrastructure needed to operate safely. The scale of the work was driven by modern care needs and the resiliency demands of keeping a coastal hospital campus operational, as well as new programmatic growth. [21] [22] [23]

New York Building Congress Members involved:
AKRF, Ennead Architects, Langan, LERA Consulting Structural Engineers, NYU Langone Health, Posillico, Trinity/JB&B, Turner Construction Co.

21 https://www.fiercehealthcare.com/hospitals-health-systems/nyu-langone-opens-pediatric-hospital-highrise-downtown-new-york-city
22 https://nyulangone.org/our-story/campus-transformation/building-the-energy-building
23 https://www.dasny.org/sites/default/files/inline-files/NYU%20Langone%20Hospitals%20Obligated%20Group%20Revenue%20Bonds%20Series%202020A.pdf

MODERNIZATION CASE STUDIES:
BULK CAN GROW FASTER THAN BEDS

UVM Medical Center, Robert E. and Holly D. Miller Building, Burlington, Vermont

UVM Medical Center's Miller Building is a clear example of modernization without heavy programmatic growth. The $187m project replaced older inpatient rooms, many of which were semi-private and located in areas built roughly 50 to 70 years earlier. The project added more than 180,000 square feet, seven floors, including two mechanical/support floors. It also included 66,000 square feet of renovation work, central plant upgrades, utility tunnel work, and MEP extensions and relocations.

Despite the scale of the project, there was no net increase in beds or the number of patients the hospital could care for at one time.[24]

Notably, the project created 128 single-bed rooms with private bathrooms, increasing single-patient rooms from roughly 40% to almost 90% across the hospital. It also added space for family members, technology, larger care stations, and staff collaboration areas.[25]

Suburban Hospital, North Building (Johns Hopkins Medicine), Bethesda, Maryland

Suburban Hospital's North Building tells a similar story. The $270m project nearly doubled the size of the hospital while the bed count stayed flat at 228. Suburban first opened in 1943 and the new North Building was the hospital's first major update since 1979. The 300,000-square-foot addition is a modern facility with private patient rooms, updated surgical and procedural space, and better patient and family areas.

The project created 108 private patient rooms as the new addition freed up space, which allowed the semi-private rooms in the older building to become private. The project also added 14 operating rooms, recovery areas, and a floor with separate ventilation capacity for pandemic conditions.[26]

Kaiser Permanente San Francisco Replacement Hospital, San Francisco, California

Kaiser Permanente's proposed San Francisco replacement hospital follows a similar pattern. The existing 367,000 square foot Geary Boulevard hospital was opened in 1954 and has 239 semi-private beds. The proposed replacement would increase the facility to 623,000 square feet and add 61 private beds. That means building area would increase by about 70%, while bed count would increase by just over 25%. The proposal also includes an expanded emergency department, and all-electric hospital design.[27]

Project	Original Facility Age	Added Space	Bed Growth	Main Driver of Bulk Growth
UVM Medical Center	Components vary from 50-70 years old	180,000 sf new tower + 66,000 sf renovation	None	Single-bed rooms
Suburban Hospital	First major update since 1979	300,000 sf, a ~100% increase	None	Single-bed rooms
Kaiser Permanente San Francisco	Existing hospital opened in 1954	256,000 sf, a 70% increase	+61 beds	Single-bed rooms

These out-of-state examples show that major hospital modernization projects are not unusual or excessive and often require considerable bulk growth even without programmatic expansion. In New York City, the same modernization pressures exist, yet they run into a much more constrained land use environment. Modern care takes up modern space. A healthcare system that serves millions of patients each year needs a regulatory environment which recognizes that such modernization is a public good.

24 https://www.whiting-turner.com/projects/healthcare/uvm-robert-e-and-holly-d-miller-building/
25 https://www.uvmfoundation.org/s/1690/images/gid2/editor_documents/foundation/cases/miller_building_case_statement.pdf
26 https://www.hopkinsmedicine.org/news/articles/2020/01/campus-expansion-transforms-the-care-experience
27 https://www.beckershospitalreview.com/capital/kaiser-plans-new-hospital-in-san-francisco-8-things-to-know/

MODERNIZATION OFTEN TRIGGERS MULTIPLE LAND USE ISSUES

The land use challenge for healthcare facilities is more complex than bulk alone. Higher FAR is important, especially when hospitals need to modernize older buildings within constrained zoning envelopes. But many projects also involve a broader mix of land use actions, zoning approvals, site changes, public approvals, or other discretionary steps, and most of them are sequential rather than parallel.

These issues vary by project, and they can arise even when the goal is straightforward. Here are some examples:

Project	Select Additional Land Use Actions	Approval Timeline	Significance
Hospital for Special Surgery River Building	Special permit to build a 12-story hospital facility in air space above the FDR Drive; loading modification; special permit for East Wing enlargement; City Map amendment to close portions of the FDR Drive and related volumes; zoning text amendment; non-ULURP certifications tied to the amended 1973 agreement.	Filed February 14, 2006. City Council approved October 7, 2008.	The project required air-rights, mapping, loading, and agreement-related actions beyond basic zoning bulk.
SPARC Kips Bay	Zoning map amendment from R8 to C6-4; zoning text amendment to map MIH; special permit for laboratory use; special permit to modify height and setback; disposition of City-owned property; acquisition of real property by the City; site selection and acquisition for an OCME forensic pathology center; City Map change.	Filed May 28, 2024. City Council approved February 13, 2025.*	Major life sciences and healthcare-related development often depends on zoning, public land, City participation, and institutional planning moving together.
455 First Avenue / Innovation East	Zoning map amendment from R8/R8 with C2-5 overlay to C6-4; zoning text amendment to map MIH; special permit to modify height and setback for laboratory use.	Filed May 3, 2024. City Council approved February 13, 2025.*	Even a life sciences building tied to the Kips Bay ecosystem required several coordinated approvals.
Lenox Hill Hospital (Northwell Health)	Zoning map amendment; zoning text amendment creating a new ZR 74-904 hospital special permit; CPC special permit for additional community facility floor area and bulk modifications; zoning authorizing for floor area generated by proposed 77th Street subway station improvements, including ADA-accessible station access.	Filed 2024. City Council approval 2026	A contemporary NYC hospital modernization requiring zoning text amendments to enable the project.

** Filed-to-approval times expedited due to projects being NYC government priorities.*

City Planning plays an important role in this work. Many major healthcare and life sciences projects have moved forward with some form of City involvement, including planning support, site dispositions, co-sponsorship, anchor tenancy, zoning approvals, or other project-specific tools. The Building Congress appreciates the hard work City Planning staff do to help complicated projects move through complicated rules. The next step is to make that pathway clearer and more predictable, so essential healthcare projects do not depend on one-off solutions every time modernization is needed.[28] [29] [30]

28 https://www.nyc.gov/assets/planning/download/pdf/about/cpc/060333.pdf
29 https://www.nyc.gov/assets/planning/download/pdf/about/cpc/240369.pdf
30 https://www.nyc.gov/assets/planning/download/pdf/about/cpc/240342.pdf

THE IMPLICATIONS OF RED TAPE

The cost of delay is too often the cost of doing business in New York. According to the Citizens Budget Commission (CBC), the median discretionary land use application took two and a half years from formal filing with City Planning through ULURP, with pre-certification and environmental review counting for roughly 80% of the timeline. For hospitals, the timeline often starts even earlier. Before entering a discretionary approval process, providers may spend years defining the programmatic need, testing designs, and determining the bulk or zoning relief required. After years of planning and approvals, a hospital may finally start construction and find that clinical needs and regulations have already changed. Beyond ULURP there are further approvals which require extensive processes, such as the Board of Standards and Appeals (BSA) which handles variance and special permit applications for hospital and other community facility projects that do not require a zoning text amendment or map change. The BSA process can take up to two years.

CBC estimated that a two-year discretionary approval process can increase total development costs by 11 to 16 percent, before any scope changes are considered.[31] Applied to the MTA's $5.5 billion Interborough Express, that level of delay could translate into roughly $605 million to $880 million in added costs. For healthcare facilities, the stakes are even higher because delays also postpone the delivery of modern beds, operating rooms, emergency capacity, and other revenue-generating services. NYC Health and Hospitals - Bellevue alone generates about $1.46 billion in annual net patient revenue.[32] While that does not mean every dollar would be lost during a delayed modernization, it does show the scale of revenue capacity tied up when major hospital projects spend years in reviews instead of moving into construction.

Delay also has a direct workforce cost. SPARC Kips Bay shows how many jobs are tied to major healthcare and life sciences construction projects. NYCEDC estimates that the $1.6 billion public investment will create more than 15,000 jobs, including 12,000 construction jobs and 3,100 permanent life sciences jobs. When red tape delays projects of this scale, it delays real construction jobs, economic activity, and long-term employment.[33] These are exactly the kinds of good-paying, middle-class construction jobs New York should be moving faster to create.

PRE-UNIFORM LAND USE REVIEW PROCEDURE TIMELINE [34] [35]

Internal hospital planning and project definition

OFTEN 1 TO 3 YEARS

The provider defines the clinical need, tests design options, identifies operational requirements, and determines whether added bulk or zoning relief is needed.

DCP pre-application, pre-certification, and environmental review

ABOUT 2 YEARS

The applicant works with City Planning to prepare the application, resolve technical issues, complete environmental review, and reach certification readiness.

31 https://cbcny.org/research/improving-new-york-citys-land-use-decision-making-process
32 https://www.definitivehc.com/resources/healthcare-insights/top-hospitals-new-york-net-patient-revenue
33 https://edc.nyc/press-release/nycedc-announces-skanska-construction-manager-sparc-kips-bay-first-its-kind-life

UNIFORM LAND USE REVIEW PROCEDURE TIMELINE

ULURP Certification
DAY 0

City Planning certifies the application as complete, starting the formal public review clock.

Community Board review
60 DAYS

Community Boards have 60 days after certification to hold a public hearing and vote on a land use proposal.

Borough President review
30 DAYS

The Borough President reviews the application and issues an advisory recommendation.

City Planning Commission review
60 DAYS

The CPC holds a public hearing and votes to approve, approve with modifications, or disapprove the application.

City Council review
50 DAYS

The Council reviews the application and may approve, modify, or disapprove it.

Mayoral review
5 DAYS

The Mayor may veto the Council action, subject to Council override.

Post-approval permits and construction readiness
VARIES

The project moves into building permits, agency approvals, financing, construction sequencing, and implementation.

Article 78

Members of the public have up to 120 days to file an Article 78 challenge, which is the legal mechanism for filing an objection against a ULURP determination. This can delay a project for years, force modifications, or potentially stop a project even after it has completed the public review process.

34 https://www.nyc.gov/content/planning/pages/planning/public-review
35 https://cbcny.org/research/improving-new-york-citys-land-use-decision-making-process

ENCOURAGING SIGNS OF PROGRESS

The good news is, we've seen how much and how fast we can build when red tape is eliminated. During the COVID-19 pandemic, the State removed numerous procurement and construction constraints, allowing DDC to use CM-Build, accelerated RFPs, reduced public notice requirements, and faster approvals from other agencies.

The results were immediate: Two field hospitals totaling 1,100 beds (one was built in 11 days), 28 testing sites, four laboratory upgrades, and three COVID Centers of Excellence. The average construction time was seven days for testing sites, 28 days for field hospitals, 35 days for lab upgrades, and 192 days for the Centers of Excellence, including design time. This level of work would have taken almost six years otherwise.[36] The pandemic was an emergency, but it proved an important point: when government reduces procedural friction, healthcare facilities can be delivered far faster in response to public need.

The 1961 Zoning Resolution recognized that hospitals, schools, and other community facilities need more space than ordinary residential buildings. It gave community facilities special bulk treatment in residential districts because these uses serve a public purpose and need room to function. That was the right instinct. The issue is that a framework that may have seemed adequate for hospitals in 1961 cannot be treated as adequate for modern medicine today. No patient today would choose 1961-era medical science for a surgery, a diagnosis, or a hospital stay. New York's land use rules should not force healthcare facilities to operate as if that era never ended, back before Medicare and Medicaid even existed.[37]

The City has also shown a real willingness to modernize zoning and land use. Through the City of Yes, the Department of City Planning led a major effort to update zoning rules that affect housing production, economic growth, and decarbonization efforts. The City of Yes for Economic Opportunity tackled outdated zoning barriers affecting businesses and job-generating uses across the city, including important clarifications regarding labs and life sciences buildings.[38] [39]

City of Yes for Economic Opportunity gave laboratories and life sciences facilities a clearer as-of-right path in more locations, generally based on the idea that many modern life sciences spaces are research and testing environments, not heavy manufacturing centers or factories. For 'non-production laboratories,' that means more space can now be located in commercial and manufacturing areas without going through City Planning Commission review when the project already complies with building, fire, and safety rules. It also means new floor plans and site plans for as-of-right lab uses no longer have to wait for extensive environmental reviews, which gives labs more room to adjust layouts as research, equipment, and technology changes.

City of Yes also clarified an important connection for healthcare institutions: research space connected to a hospital or university can be treated as a "community facility" use, which means it may be permitted in any zoning district where hospitals and universities already operate. This is important because clinical research often needs to be close to patient care and physicians, so allowing hospitals and universities to expand research space near their campuses has a direct practical value for improving public health.[40]

While the City of Yes is not a direct template for hospital zoning, it shows the City can update outdated rules when they no longer match how essential sectors operate, thanks to the hard-working staff at DCP and EDC. Hospitals need the same kind of practical review. Today, major healthcare facilities still rely on bulk allowances and discretionary pathways that have not kept pace with modern clinical standards, infrastructure needs, or the realities of renovating active hospital campuses.

36 https://www.nyc.gov/site/ddc/about/press-releases/2021/pr-033021-Report.page
37 https://www.nyc.gov/assets/planning/downloads/pdf/zoning/zoning-nyc/zoning_handbook_1961.pdf
38 https://edc.nyc/sites/default/files/2025-11/NYCEDC-NYC-Life-Sciences-Zoning-Reform-11-24-2025.pdf
39 https://www.nyc.gov/content/planning/pages/our-work/plans/citywide/city-of-yes-economic-opportunity
40 https://www.nyc.gov/assets/planning/downloads/pdf/our-work/plans/citywide/city-of-yes-economic-opportunity/project-description.pdf

Photo Credit: NYC EDC

SPARC Kips Bay is another sign that New York is getting more serious about building for life sciences growth. While the project isn't related to City of Yes, it does show how much the city can accomplish when we align public land use around a comprehensive plan. SPARC will transform the Hunter College Brookdale campus into more than 2 million square feet of academic, health, and life sciences space, with training facilities tied to CUNY. The project is expected to create more than 15,000 jobs and generate about $42 billion in economic impact over 30 years. The takeaway for healthcare modernization is clear: coordinated land use, public investment, and workforce planning can help New York deliver needed facilities faster while supporting major job growth. This type of planning meets immediate public needs while growing the industries and jobs that will shape the city's future.[41]

41 https://edc.nyc/press-release/mayor-nycedc-celebrate-historic-day-nyc-life-sciences-industry

RECOMMENDATIONS

1. Create an as-of-right pathway for healthcare modernization projects that require added bulk to meet modern standards, with 20% or less net bed growth.

2. Increase allowable FAR broadly for healthcare community facility uses to better reflect the space needs of modern hospitals.

3. Create targeted bulk and FAR allowances for safety-net, public, and community hospitals, paired with expedited approvals and greater capital support for institutions serving high-need communities.

4. Streamline ULURP and related reviews for healthcare modernization projects, including through Charter Revision reforms where appropriate.

5. Create a healthcare-specific mechanical bulk allowance so modern hospital infrastructure can be accommodated within zoning envelopes, even where mechanical space is already excluded from FAR.

6. Broaden life sciences definitions to include more hospital-based research, diagnostics, testing, translational medicine, and other healthcare-adjacent innovation uses.

7. Streamline the environmental review process for hospital modernization projects.

8. Encourage healthcare growth across all five boroughs by giving hospitals, outpatient centers, and other care facilities more flexibility to expand where New Yorkers live, work, and need access to care.

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SPECIAL THANK YOU TO THE ENTIRE HEALTHCARE & LIFE SCIENCES COMMITTEE
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