EXECUTIVE SUMMARY

Mount Sinai Hospital – Mount Sinai Hospital of Queens (MSQ), a division of The Mount Sinai Hospital, is submitting this Administrative Review Certificate of Need Application that seeks approval to construct a new 21-bed Intensive Care Unit (ICU) in space currently being used for storage and a small conference center on the 6th floor of MSQ's main hospital campus building, located at 25-10 30th Avenue, Long Island City (Queens County), New York 11102. MSQ currently operates an eight-(8)-bed ICU that is outdated, undersized and has been operating between 81% and 87% occupancy for the past several years, which is above the 65-75% average that is considered optimal for ICU beds. A Health Equity Impact Assessment is included with this Application.

MSQ plans to build a new 21-bed ICU by adding 13 ICU beds to its operating certificate, increasing the total certified beds at MSQ from 228 to 241 beds. After completion of this project, MSQ will relocate some of its existing Medical/Surgical beds to the area currently occupied by the eight-(8)-bed ICU. This relocation aims to enhance the efficiency and operations of the Medical/Surgical beds overall. The new ICU will also include a Class 2 Procedure room to provide fluoroscopy-guided peripherally inserted central catheter (PICC) line placements, central line placements and dialysis catheter placements.

Currently, the limited ICU capacity restricts MSQ's service expansion, its ability to manage more complex cases and treatment of critically ill patients. Furthermore, MSQ experiences backlogs and boarding in the emergency department (ED), as patients needing telemonitoring cannot always be transferred to the ICU. This leads to further capacity challenges and inconveniences for patients, families and staff. Additionally, many ICU-eligible patients are transferred to other hospitals in the Mount Sinai Health System, especially The Mount Sinai Hospital, causing additional strain there—where ICU occupancy often exceeds 95%. In recent years, more than 125 ICU-eligible patients per year have been transferred out of MSQ.

With increasing patient acuity and frequent ICU crowding, expanding and modernizing the ICU at MSQ is essential for ensuring timely access to critical care, reducing ED congestion and improving overall patient flow. The new ICU will also support more complex surgeries, leading to better outcomes and keeping advanced care accessible within the local community. Nearly tripling ICU capacity will reduce ED boarding, decrease patient transfers out of Queens County and strengthen surge preparedness. Most importantly, expanded critical care capacity will allow MSQ to grow its surgical program and deliver high-acuity care locally.

The Total Project Cost will be funded with cash and construction will take approximately 16 months to complete.

New York State Department of Health
Certificate of Need Application

Schedule 1

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Cameron R. Hernandez, M.D., President and COO			
BUSINESS STREET ADDRESS			
25-10 30th Avenue			
CITY	STATE	ZIP	
Long Island City (Queens County)	New York	11102	
TELEPHONE	E-MAIL ADDRESS		
(718) 932-1000	cameron.hernandez@mssm.edu		

The applicant's lead attorney should be identified:

ATTORNEY		
NAME	FIRM	BUSINESS STREET ADDRESS
N/A		
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

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

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

The applicant's lead accountant should be identified:

ACCOUNTANT		
NAME	FIRM	BUSINESS STREET ADDRESS
N/A – please contact consultant		
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER		
NAME	FIRM	BUSINESS STREET ADDRESS
Samir H. Abourjeili	S. Rejeili Architect, PLLC	147 West 35th Street, Suite 404
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
New York, NY 10001	(212) 460-5511	sra@srejeiliarchitect.com

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

Other Facilities Owned or Controlled by the Applicant NOT APPLICABLE

Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

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

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

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

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

Out-of-State Affiliated Facilities/Agencies NOT APPLICABLE

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

Facility Type	Name	Address	State/Country	Services Provided

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

MOUNT SINAI HOSPITAL – MOUNT SINAI HOSPITAL OF QUEENS

1. Health System Network Statement
2. Curriculum Vitae – Medical Director
3. Letters of Support

MOUNT SINAI HOSPITAL

ARTICLE 28 NETWORK DESCRIPTION

Mount Sinai Hospitals Group, Inc. (MSHG), a not-for-profit corporation, is the active parent and co-operator of Mount Sinai Hospital (including its division, Mount Sinai Hospital of Queens), Mount Sinai Brooklyn, Mount Sinai Morningside, Mount Sinai West, the New York Eye and Ear Infirmary of Mount Sinai and Mount Sinai South Nassau.

The Mount Sinai Hospital (MSH) is located at One Gustave L. Levy Place, New York (New York County), New York 10029. MSH also has a division, Mount Sinai Hospital of Queens, which is located at 25-10 30th Avenue, Long Island City (Queens County), New York 11102. Mount Sinai Brooklyn is located at 3201 Kings Highway, Brooklyn (Kings County), New York 11234. Mount Sinai Morningside (formerly known as Mount Sinai St. Luke's) is located at 1111 Amsterdam Avenue, New York (New York County), New York 10025. Mount Sinai West is located at 1000 Tenth Avenue, New York (New York County), New York 10019. New York Eye and Ear Infirmary of Mount Sinai is located at 310 East 14th Street, New York (New York County), New York 10003. Mount Sinai South Nassau is located at One Healthy Way, Oceanside (Nassau County), New York 11572.

The following table provides information on operating certificate numbers and PFI numbers for the above-referenced facilities:

Facility Name	Operating Certificate #	PFI #
The Mount Sinai Hospital	7002024H	1456
Mount Sinai Hospital of Queens	7002024H	1639
Mount Sinai Brooklyn	7002002H	1324
Mount Sinai Morningside	7002032H	1469
Mount Sinai West	7002032H	1466
New York Eye and Ear Infirmary of Mount Sinai	7002026H	1460
Mount Sinai South Nassau	2950001H	0527

Working Capital Financing Plan

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

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

Titles of Attachments Related to Borrowed Funds	Filenames of Attachments
Example: *First borrowed fund source*	Example*: first_bor_fund.pdf*
N/A	

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

Any working capital needs will be funded through the ongoing operations of Mount Sinai Hospital – Mount Sinai Hospital of Queens. Please refer to the Schedule 5 Attachment for a Monthly Cash Flow Analysis showing sufficient cash throughout the first year of operations. Please also refer to the Schedule 9 Attachment for financial statements.

2. Pro Forma Balance Sheet

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

Titles of Attachments Related to Pro Forma Balance Sheets	**Filenames of Attachments**
Example: *Attachment to operational balance sheet*	Example: *Operational_bal_sheet.pdf*
N/A	

MOUNT SINAI HOSPITAL – MOUNT SINAI HOSPITAL OF QUEENS

Monthly Cash Flow Analysis

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: 12/8/2025	Revised Schedule 6 submission date: NA
Does this project amend or supersede prior CON approvals or a pending application? No If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: Construct a new 21-bed Intensive Care Unit	
Site Location: 25-10 30th Avenue, Long Island City (Queens County), New York, 11102	
Brief description of current facility, including facility type:	

It is a shell space currently being used for Storage and a small Conference center on the 6th floor of the hospital building at Mount Sinai Hospital of Queens.	
Brief description of proposed facility: A new 21-bed Intensive Care Unit with required support spaces on one floor	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. On the 6th Floor of existing hospital building. Will be Institutional "I-2" occupancy.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: Single occupancy floor. Smoke and fire separations provided per sleeping units requirements.	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	Not Applicable
Relationship of spaces conforming with Article 28 space and non-Article 28 space: Entire space will be conforming to Article 28	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. 2018 FGI being utilized	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. This project requires modification to existing infrastructure systems, heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection.	Yes
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. The MEP services provided for this facility will be tied into the existing building infrastructure systems that has the capacity to serve this floor.	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. The existing space is a shell space with one conference room and associated toilets. Chilled water is provided by existing steam absorber chillers located on the roof above the 6th floor. Hot water re-heat is provided by the existing boilers located on the roof above the 6th floor. There are a total of six (6) existing air handling units on the roof where their ductwork is headered together in tandem. AHU1/ 2 serve the 3rd floor, AHU3/4 serves floors cellar through 5th floor, and AHU5/6 serves cellar, 2nd through 5th floor. The conference room is served by a single VAV box tied into the existing air handling units (AHU5/6) located on the roof above.. New HVAC duct distribution will be provided by a new hospital grade air handling unit from building roof top unit. Required exhaust air will be tied to the existing building exhaust system and new isolation exhaust fans. A dedicated ceiling mounted AC unit will be provided for the new procedure room. New VAV boxes with hot water re-heat coils shall be provided and zoned per the proposed layout.. Existing space is sprinklered and will be reconfigured to provide coverage for proposed plan. Existing electrical service on the floor currently has normal and emergency power. Electric service will comply with branch separation (EES) and will connect to the existing Electrical system. New electrical panels will be provided to service new space program. Emergency lighting will be connected to a life safety branch of power. Nurse call shall be provided per FGI guidelines requirements and connected into the existing hospital nurse call system. Domestic cold, hot, and hot water return piping, sanitary drain and vent piping will be distributed to serve the proposed program. Medical gases (Oxygen, Vacuum, and Air) and connected to existing main Hospital systems. Existing medical vacuum pumps are NFPA 99 compliant, connected to emergency power, and	

operate in lead lag (one running one on stand-by). Medical air is supplied at 50PSI to the 6th floor by NFPA 99 compliant compressors that operate in lead lag. New Zone valve boxes will be provided based on the new layout. All patient rooms will have dialysis box provisions to accommodate self-contained dialysis machines.
Describe existing and or new work for fire detection, alarm, and communication systems: All initiation and notification devices are circuited to its associated existing Fire Alarm Control Panel (FACP) New fire alarm smoke detectors, Strobes and Horn/Strobes will be installed as per NFPA 72 Fire Alarm code and connected to base building fire alarm system.
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. N/A
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. No
Does the project comply with ADA? If no, list all areas of noncompliance. Yes
Other pertinent information: Click here to enter text.

Project Work Area	**Response**
Type of Work	Renovation
Square footages of existing areas, existing floor and or existing building.	+/-126,000 sf existing building area
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	+/-18,000 sf floor
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Less than 50% of the building
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type II (222)
Building Height	98 ft
Building Number of Stories	6
Which edition of FGI is being used for this project?	2018 Edition of FGI
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	Yes
If a high-rise, does the building have a generator?	Yes
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 18 New Health Care Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Conference center, "Business" occupancy.	Yes
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	No
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Shell space currently used for storage. Proposed ICU will be Article 28	Yes
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	No
Will spaces be permanently relocated to allow the construction of this project?	Yes

If yes, where will this space be? Conference center will be relocated to another hospital building	
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Construct 21 new ICU beds, existing 8 ICU beds to revert to Med / Surg beds.	Increase
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	Not Applicable
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	Yes
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Yes
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Yes
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Yes
Does the project involve a pool?	No

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

MOUNT SINAI HOSPITAL – MOUNT SINAI HOSPITAL OF QUEENS

Architectural Documents

1. Architect Certification
2. Architectural Narrative
3. Functional Space Program
4. Drawings

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS
ARCHITECTS & ENGINEERS

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

Date: December 8, 2025
CON Number: TB D
Facility Name: Mount Sinai Queens
Facility ID Number: ~~1858~~ XXXX 1639
Facility Address: Mount Sinai Queens, ~~30 Xxxxxxxxxx Street, Long Island City, NY 11102~~
25-10 30th Avenue, Long Island City (Queens County), New York, 11102
NYS Department of Health/Office of Health Systems Management
Center for Health Care Facility Planning, Licensure, and Finance
Bureau of Architectural and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

To The New York State Department of Health:

I hereby certify that:

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

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

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

   a. X 712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. __715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:

   2018 FGI being utilized

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

S. Rejeili Architect PLLC
147 West 35 Street Suite 404 New York NY 10001
t 212 460 5511 f 212 460 5411 sra@srejeiliarchitect.com

New York State Department of Health
Certificate of Need Application

Intensive Care Unit **December 8, 2025**
Mount Sinai Queens - 6th Floor
25-10 30th Avenue, Long Island City (Queens County),
New York, 11102

ARCHITECTURAL NARRATIVE

The project consists of construction of a new Intensive Care Unit in approximately 18,000 SF of shell space, currently being used for storage, located on the 6th Floor of the new Pavilion building.

The Functional Space Program is as indicated on the attached documents and plans. It includes a 21-bed Intensive Care Unit, single occupancy rooms with a toilet including 4 (AII) Isolation rooms. All spaces will be ADA compliant.

Also provided are Central Nurses Stations and Sub-Stations, Reception and Family Waiting. Support spaces such as Staff Lounge, Staff Toilets, On Call Room, Clean Supply, Soiled Utility, Environmental Services Closets, etc., are provided within the unit on the same floor.

The project will be constructed in a single phase as illustrated on the proposed plans without any disruption to the operation of the existing occupied spaces on floors below.

The proposed work will not affect life safety and egress of the existing Floors and will not interrupt their operations. Temporary protection will be provided as necessary per Infection Control requirements to protect the patients and public.

Architectural work such as interior partitions, ceilings and finish materials, etc., will comply with the Guidelines for Hospital Facilities environment.

MEP scope of work will be provided to accommodate the Functional Space Program.
The MEP services provided for this facility will be in compliance with applicable codes and regulations and will be tied into the existing building infrastructure systems that has the capacity to serve this floor.

New HVAC duct distribution will be provided and will be tied to existing duct risers from building roof top units. Required air exhaust will be tied to the existing building exhaust system. Existing space is sprinklered and will be reconfigured to provide coverage for proposed plan. Electric service will comply with branch separation (EES) and will connect to the existing Electrical system. Medical gases (Oxygen, Vacuum and Air) and a Nurse Call system will also be provided and connected to existing main Hospital systems. All patient rooms will have dialysis box provisions to accommodate self-contained dialysis machines.

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New York State Department of Health
Certificate of Need Application

Intensive Care Unit **December 8, 2025**
Mount Sinai Queens - 6th Floor
25-10 30th Avenue, Long Island City (Queens County),
New York, 11102

FUNCTIONAL SPACE PROGRAM

Functional Space	Planning Criteria	Unit Area sf	No. Of Spaces	Total sf
A. Admitting / Reception				
1. Visitor Lounge	33 Persons Water fountain / Bottle filler	140-350	2	490
2. Public Toilet	Non-Gender, ADA Baby Changing Station	55	1	55
B. Intensive Care Unit Area				
1. Nurses Stations (3)	4 Staff Handwash sink 4 Staff Handwash sink 6 Staff Handwash sink	180 170 250	1 1	180 170 250
2. Nursing Director Office		95	1	95
3. ICU Director Office		80	1	80
4. Physician Leader Rooms	Room (1) Room (2)	65 60	1 1	65 60
5. Multi-Purpose Room		155	1	155
6. ICU Rooms	Handwash Sink, Med Gases Dialysis Box Emergency Call System Night Light, 2 Family Seats. Toilets with Bed-Pan Washer	210-280 37-45	17 17	4,430 679
ICU (AII) Isolation Rooms	Same as above Toilets with Bed-Pan Washer	265-290 40	4 4	1,085 160
7. Procedure Room Fluoroscopy-guided peripherally inserted central catheter (PICC), central lines and dialysis catheters	Class 2 room environment Table, Med equip & carts, etc. mobile Injector, Handwash Sink, Soiled Sink, Documentation desk, Stool, Portable C-Arm Med Gases (2) O2, (2) V, (1) A	355	1	355

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8.	Nurse Manager Office		65	1	65
9.	Nurse Assistant Office		51	1	51

C. <u>Support</u>

1.	Med Room / Safety Zone	Handwash Sink with Eyewash Med Refrigerators, Pyxis, Equipment	70-95	2	165
2.	Nourishment Room	Handwash Sink, Ice Maker Food Refrigerator, Microwave	85	1	85
3.	Alcove	Crash Carts & COWs	10-40	5	100
4.	Clean Supply	Supply Carts	110	1	110
5.	Clean Workroom	Handwash sink, Shelving Units	70	1	70
6.	Physical Therapy Equipment Storage		80	1	80
7.	Supply Storage		44	1	44
8.	Respirators Storage		50	1	50
9.	Equipment Storage		50	1	50
10.	Soiled Workroom	Clinical Sink Handwash Sink & Counter	65	1	65
11.	Soiled Holding	Handwash Sink & Counter	90	1	90
12.	Environmental Services (EVS)	Mop Sink & Shelf	45-47	2	92
13.	Equipment Supply Storage	Shelving Units Equipment Storage (20sf/Room)	420	1	420
14.	Stretcher / Wheelchair Alcove		45	1	45
15.	Staff Toilets	Non-Gender, ADA one with Shower	40-65	3	155
16.	On-Call Room	Bed, Bedside Table, Chair, Closet, Tel., Mirror	100	1	100

S. Rejeili Architect PLLC
147 West 35 Street Suite 404 New York NY 10001
t 212 460 5511 f 212 460 5411 sra@srejeiliarchitect.com

17. Staff Lounge / Lockers	Pantry Unit, Food Refrigerator Microwave, Coffee Maker Handwash Sink, TV, Bench, (13) Double Tier Lockers, etc.	175	1	175
18. Pump Closet	Existing	25-40	Exist 2	65
19. IT Telecom / Data	Existing	135	Exist 1	135
20. Electrical Room	Existing	100	Exist 1	100
21. Electrical Panels Closets		6	2	12
22. Verizon IT Room		86	1	86

sf - square feet	**Total:**	10,659sf
gsf - gross square feet	**Grossing Factor:**	1,69
Note: Areas indicated are approximate	**Total:**	+18,000gsf

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

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

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☐
2.15	Will the project result in a major adverse effect on air quality?	☐	☐
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	☐
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	☐
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	☐
2.19	Will the project have any adverse impact on health or safety?	☐	☐
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	☐
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	☐
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	☐
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☐
Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☒	☐
	Agency Name:	NYC Dept of Buildings	
	Contact Name:	John Raine, RA	
	Address:	280 Broadway	
	State and Zip Code:	New York, NY 10007	
	E-Mail Address:	N/A	
	Phone Number:	(212) 393-2615	
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		

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

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

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

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

https://www.fema.gov/media-library-data/1582295171786-6506170c5f54026f585e44e2fc94950d/FF086033_ElevCert_FormOnly_RE_11Feb2020.pdf

NOT APPLICABLE

New York State Department of Health
Certificate of Need Application
Schedule 8A Summarized Project Cost and Construction Dates

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

1.) Project Cost Summary data:

	Total	Source
Project Description:		
Project Cost	$27,009,139	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$27,009,139	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$3,898,411	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	N/A	Schedule 10
Cost/Per Square Foot for Renovation Construction	$777.78	Schedule10
Total Operating Cost	$4,485,542,092	Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.0%	Schedule 9
Depreciation Life (in years)	7 Years Equipment; 25 Years Construction	Schedule 13 Attachment

2) Construction Dates

Anticipated Start Date	9/1/2026 (on or before)	Schedule 8B
Anticipated Completion Date	1/1/2028 (on or before)	

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

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

Constants	Value	Comments
Design Contingency - New Construction	N/A	Normally 10%
Construction Contingency - New Construction	N/A	Normally 5%
Design Contingency - Renovation Work	10.00%	Normally 10%
Construction Contingency - Renovation Work	10.00%	Normally 10%
Anticipated Construction Start Date:	9/1/2026 (on or before)	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	5/1/2027 (on or before)	as mm/dd/yyyy
Anticipated Completion of Construction Date	1/1/2028 (on or before)	as mm/dd/yyyy
Year used to compute Current Dollars:	2026	

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

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

	A	B	C
Item	**Project Cost in Current Dollars**	**Escalation amount to Mid-point of Construction**	**Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$14,000,000	$625,389	$14,625,389
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$1,400,000	$62,539	$1,462,539
3.2 Construction Contingency	$1,400,000	$62,539	$1,462,539
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$120,000	$0	$120,000
4.3 Architect/Engineering Fees	$900,000	$0	$900,000
4.4 Construction Manager Fees	$1,400,000	$0	$1,400,000
4.5 Other Fees (Consultant, etc.)	$1,245,000	$0	$1,245,000
Subtotal (Total 1.1 thru 4.5)	$20,465,000	$750,467	$21,215,467
5.1 Movable Equipment (from Sched 11)	$3,898,411	$0	$3,898,411
5.2 Telecommunications	$1,895,261	$0	$1,895,261
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$26,258,672	$750,467	$27,009,139
7.1 Financing Costs (Points etc.)	$0		$0
7.2 Interim Interest Expense:: $ - At - % for - months	$0		$0
8. Total Project Cost: w/o CON fees - Total 6 thru 7.2	$26,258,672	$750,467	$27,009,139
Application fees: 28, 36 and 40. See Web Site.	$2,000		$2,000
9.2 Additional Fee for projects with capital costs. Not applicable to "Establishment Only" projects. See Web Site for applicable fees. (Line 8, multiplied by the appropriate percentage.) Enter Multiplier i.e.: .25% = .0025 --> 0.30%	$81,027	$0	$81,027
10 Total Project Cost with fees	$26,341,699	$750,467	$27,092,166

Schedule 9 Proposed Plan for Project Financing:

I. Summary of Proposed Financial plan

Check all that apply and fill in corresponding amounts.

	Type	Amount
☐	A. Lease	$
☒	B. Cash	$27,092,166
☐	C. Mortgage, Notes, or Bonds	
☐	D. Land	$
☐	E. Other	$
☒	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$27,092,166

If refinancing is used, please complete area below. **N/A**

☐	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.	☒	N/A
2. Attach a copy of the proposed lease(s).	☒	N/A
3. Submit an affidavit indicating any business or family relationships between principals of the landlord and tenant.	☒	N/A
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	☒	N/A
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.	☒	N/A
6. Attach two letters from independent realtors verifying square footage rate.	☒	N/A
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.	☒	N/A

B. Cash

Type	Amount
Accumulated Funds	$27,092,166
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$
TOTAL CASH	$27,092,166

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	See Table above
2. Attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations. In establishment applications for **Residential Health Care Facilities**, attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date for **the subject facility and all affiliated Residential Health Care Facilities**. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented (or to be implemented in the case of the subject facility) to improve operations.	☐	Please refer to the Financial Narrative under the Schedule 9 Attachment for additional information.
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☒	N/A
4. Attach a full and complete description of the assets to be sold, if applicable.	☒	N/A
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

	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).	☒	N/A
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	☒	N/A
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.	☐	100% 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 ☐	☒	N/A

C. Mortgage, Notes, or Bonds **NOT APPLICABLE**

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

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

D. Land

NOT APPLICABLE

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

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

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

E. Other

NOT APPLICABLE

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

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

F. Refinancing

NOT APPLICABLE

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

MOUNT SINAI HOSPITAL – MOUNT SINAI HOSPITAL OF QUEENS

1. Financial Narrative
2. Financial Statements

Mount Sinai Hospital – Mount Sinai Hospital of Queens

FINANCIAL NARRATIVE

Mount Sinai Hospital – Mount Sinai Hospital of Queens (MSQ), a division of The Mount Sinai Hospital, is submitting this Administrative Review Certificate of Need Application that seeks approval to construct a new 21-bed Intensive Care Unit (ICU) in space currently being used for storage and a small conference center on the 6th floor of MSQ's main hospital campus building, located at 25-10 30th Avenue, Long Island City (Queens County), New York 11102. MSQ currently operates an eight-(8)-bed ICU that is outdated, undersized and has been operating between 81% and 87% occupancy for the past several years, which is above the 65-75% average that is considered optimal for ICU beds.

The Total Project Cost (TPC) is $27,092,166 and will be funded entirely through the existing funds of the Hospital. MSQ reserves the right to convert to financing this project if it deems that necessary, subject to Department modification regulations. Please refer to the Schedule 9 Attachment for MSQ's Financial Statements.

MSQ plans to build a new 21-bed ICU by adding 13 ICU beds to its operating certificate, increasing the total certified beds at MSQ from 228 to 241 beds. Currently, the limited ICU capacity restricts MSQ's service expansion, its ability to manage more complex cases and treatment of critically ill patients. Furthermore, MSQ experiences backlogs and boarding in the emergency department (ED), as patients needing telemonitoring cannot always be transferred to the ICU. This leads to further capacity challenges and inconveniences for both patients, families and staff. Additionally, many ICU-eligible patients are transferred to other hospitals in the Mount Sinai Health System, especially The

Mount Sinai Hospital, causing additional strain there—where ICU occupancy often exceeds 95%. In recent years, more than 125 ICU-eligible patients per year have been transferred out of MSQ.

With increasing patient acuity and frequent ICU crowding, expanding and modernizing the ICU at MSQ is essential for ensuring timely access to critical care, reducing ED congestion and improving overall patient flow. The new ICU will also support more complex surgeries, leading to better outcomes and keeping advanced care accessible within the community. Nearly tripling ICU capacity will reduce ED boarding, decrease patient transfers out of Queens County and strengthen surge preparedness. Most importantly, expanded critical care capacity will allow MSQ to grow its surgical program and deliver high-acuity care locally.

With this expansion, MSQ expects to treat sicker patients in its ICU, resulting in a higher case mix and longer average stays. Volume is also anticipated to grow as fewer patients will need to be transferred out and the hospital's services broaden. Alleviating ED bottlenecks and capacity issues will further support this growth. According to the projections below, by Year 3, MSQ's ICU occupancy should reach optimal levels, enabling the Hospital to still handle surges while maintaining high-quality care.

	2025	Year 1	Year 2	Year 3	Year 4	Year 5
ICU Cases	623	758	836	913	991	1,069
ICU Days	2,370	3,881	4,280	4,675	5,074	5,473
Avg LOS	3.80	5.12	5.12	5.12	5.12	5.12
Existing ICU Beds	8	21	21	21	21	21
Total Bed Days (365 days/Year)	2,920	7,665	7,665	7,665	7,665	7,665
ICU Occupancy	81.2%	50.6%	55.8%	61.0%	66.2%	71.4%

MSQ is projecting additional inpatient volume and revenue as a direct result of this project as depicted on Schedule 13 and based on the reasons stated above. Incremental expenses associated with this incremental volume were determined based on the experience of the applicant providing the

services contemplated in this Application. The number and mix of staff and the operating expenses for this project are based on MSQ's experience treating its existing patients and for the provision of optimal staffing efficiencies. Likewise, incremental operating revenues by payer and visit type are based on the experience of MSQ. MSQ is projecting additional supply, staff and labor expenses due to the increase in ICU rooms and volume, as well as additional depreciation expenses related to the construction costs. Although Year 1 of this project results in an incremental operating loss, by Year 3 of this project, there will be a positive incremental operating gain. The Mount Sinai Hospital overall, which includes Mount Sinai Hospital – Mount Sinai Hospital of Queens, will continue to have a positive overall operating margin in Year 1 and Year 3 of this project.

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
		Please refer to the Schedule 11 Attachment				$ 3,898,411

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:	$ 3,898,411

Table 2 - Equipment being replaced:

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

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

Total estimated value of equipment being replaced: Subproject 1	
Total estimated value of equipment being replaced: Subproject 2	
Total estimated value of equipment being replaced: Subproject 3	
Total estimated value of equipment being replaced: Subproject 4	
Total estimated value of equipment being replaced: Subproject 5	
Total estimated value of equipment being replaced: Subproject 6	
Total estimated value of equipment being replaced: Subproject 7	
Total estimated value of equipment being replaced: Subproject 8	
Total estimated value of equipment being replaced: Whole Project:	0

MOUNT SINAI HOSPITAL – MOUNT SINAI HOSPITAL OF QUEENS

Equipment List

Project: 240922 Mount Sinai Queens ICU 6th Floor

Room by Room w/Pricing (Excel) TOTAL **$3,898,410.80**

Architectural Department	Extended Item Quantity	Unit Price	Extended Total	Category	Subcategory
ICU	3	$1,345.00	$4,035.00	Pump, Suction/Aspirator	General, Portable
ICU	3	$30,000.00	$90,000.00	Defibrillator	Monitor, w/Pacing
ICU	3	$2,592.00	$7,776.00	Cart, Procedure	Resuscitation
ICU	2	$579.02	$1,158.04	Wheelchair	Adult, Large
ICU	1	$7,350.00	$7,350.00	Cabinet, Warming	Single, Freestanding
ICU	1	$2,970.00	$2,970.00	Cart, Supply	Linen, 24-36 inch
ICU	1	$250.00	$250.00	Cart, Utility	Polymer
ICU	1	$918.00	$918.00	Warmer	Cleansing Bath
ICU	1	$7,350.00	$7,350.00	Cabinet, Warming	Single, Freestanding
ICU	12	$236.00	$2,832.00	Dispenser	Personal Protection, Wall Mount
ICU	1	$479.00	$479.00	Oven	Domestic, Microwave, Countertop
ICU	1	$1,199.00	$1,199.00	Refrigerator	Domestic with Freezer
ICU	1	$73.00	$73.00	Dispenser, Glove	Triple Box
ICU	1	$5,892.00	$5,892.00	Dispenser, Medication	Lock Module
ICU	1	$30,115.00	$30,115.00	Dispenser, Medication	Host (Main)
ICU	1	$30,115.00	$30,115.00	Dispenser, Medication	Auxiliary
ICU	1	$15,000.00	$15,000.00	Dispenser, Medication	Auxiliary
ICU	1	$12,636.00	$12,636.00	Refrigerator	Pharmaceutical, 1 door
ICU	1	$3,794.99	$3,794.99	Waste Disposal	Pharmaceutical, Secure
ICU	1	$516.04	$516.04	Waste Can	Bio-Hazardous
ICU	1	$1,491.70	$1,491.70	Bin	Return, Medication
ICU	1	$73.00	$73.00	Dispenser, Glove	Triple Box
ICU	1	$5,892.00	$5,892.00	Dispenser, Medication	Lock Module
ICU	1	$30,115.00	$30,115.00	Dispenser, Medication	Host (Main)
ICU	1	$30,115.00	$30,115.00	Dispenser, Medication	Auxiliary
ICU	1	$30,115.00	$30,115.00	Dispenser, Medication	Auxiliary
ICU	1	$15,000.00	$15,000.00	Dispenser, Medication	Auxiliary
ICU	1	$15,195.00	$15,195.00	Refrigerator	Pharmaceutical, 1 door
ICU	1	$12,636.00	$12,636.00	Refrigerator	Pharmaceutical, 1 door
ICU	1	$3,794.99	$3,794.99	Waste Disposal	Pharmaceutical, Secure
ICU	1	$3,794.99	$3,794.99	Waste Disposal	Pharmaceutical, Secure
ICU	1	$201.00	$201.00	Waste Disposal	Pharmaceutical, Secure, Wall
ICU	1	$516.04	$516.04	Waste Can	Bio-Hazardous
ICU	1	$1,090.00	$1,090.00	Water Treatment System	Ice Maker, Wall Mount
ICU	1	$15,800.00	$15,800.00	Ice Machine	Dispenser, Nugget, Countertop
ICU	1	$479.00	$479.00	Oven	Domestic, Microwave, Countertop
ICU	1	$1,199.00	$1,199.00	Refrigerator	Domestic with Freezer
ICU	1	$11,385.00	$11,385.00	Analyzer, Lab	Blood Gas, Point-of-Care
ICU	1	$1,500.00	$1,500.00	Analyzer, Lab	Glucose, Point-of-Care
ICU	1	$75,000.00	$75,000.00	Monitor, Central Station	General
ICU	1	$572.00	$572.00	Thermometer	Digital, Wall Mount
ICU	1	$11,385.00	$11,385.00	Analyzer, Lab	Blood Gas, Point-of-Care
ICU	1	$1,500.00	$1,500.00	Analyzer, Lab	Glucose, Point-of-Care
ICU	1	$75,000.00	$75,000.00	Monitor, Central Station	General
ICU	1	$572.00	$572.00	Thermometer	Digital, Wall Mount
ICU	1	$50,000.00	$50,000.00	Analyzer, Lab	Blood Gas, Point-of-Care
ICU	1	$3,995.00	$3,995.00	Analyzer, Lab	Glucose, Point-of-Care
ICU	1	$11,385.00	$11,385.00	Analyzer, Lab	Blood Gas, Point-of-Care
ICU	1	$1,500.00	$1,500.00	Analyzer, Lab	Glucose, Point-of-Care
ICU	1	$75,000.00	$75,000.00	Monitor, Central Station	General
ICU	1	$351.00	$351.00	Thermometer	Digital
ICU	1	$572.00	$572.00	Thermometer	Digital, Wall Mount
ICU	2	$400.00	$800.00	Bracket	Allowance
ICU	2	$35,110.00	$70,220.00	Bed	Electric, Critical Care
ICU	8	$40.03	$320.24	Bracket	Canister, Suction, Wall Mount
ICU	2	$1,300.00	$2,600.00	Compression Unit	Extremity Pump, Intermittent
ICU	8	$65.92	$527.36	Flowmeter	Oxygen
ICU	8	$58.71	$469.68	Flowmeter	Air
ICU	2	$73.00	$146.00	Dispenser, Glove	Triple Box
ICU	2	$195.67	$391.34	Hamper	Linen
ICU	8	$907.00	$7,256.00	Pump, Infusion	Single
ICU	2	$475.00	$950.00	Stand, IV	w/Support
ICU	2	$895.00	$1,790.00	Pump, Infusion	Controller, Modular
ICU	2	$30,000.00	$60,000.00	Monitor, Physiologic	Bedside
ICU	8	$750.99	$6,007.92	Regulator	Suction, Intermittent/Continuous
ICU	2	$165.52	$331.04	Safe	Electronic
ICU	2	$331.00	$662.00	Table, Overbed	General
ICU	2	$4,762.40	$9,524.80	Warmer	Patient, Hypothermia
ICU	2	$516.04	$1,032.08	Waste Can	Bio-Hazardous
ICU	19	$400.00	$7,600.00	Bracket	Allowance
ICU	19	$35,110.00	$667,090.00	Bed	Electric, Critical Care
ICU	76	$40.03	$3,042.28	Bracket	Canister, Suction, Wall Mount
ICU	19	$1,300.00	$24,700.00	Compression Unit	Extremity Pump, Intermittent
ICU	76	$65.92	$5,009.92	Flowmeter	Oxygen
ICU	76	$58.71	$4,461.96	Flowmeter	Air
ICU	19	$73.00	$1,387.00	Dispenser, Glove	Triple Box
ICU	19	$195.67	$3,717.73	Hamper	Linen
ICU	76	$907.00	$68,932.00	Pump, Infusion	Single
ICU	19	$475.00	$9,025.00	Stand, IV	w/Support
ICU	19	$895.00	$17,005.00	Pump, Infusion	Controller, Modular
ICU	19	$30,000.00	$570,000.00	Monitor, Physiologic	Bedside
ICU	76	$750.99	$57,075.24	Regulator	Suction, Intermittent/Continuous
ICU	11	$165.52	$1,820.72	Safe	Electronic
ICU	11	$331.00	$3,641.00	Table, Overbed	General
ICU	11	$4,762.40	$52,386.40	Warmer	Patient, Hypothermia
ICU	11	$516.04	$5,676.44	Waste Can	Bio-Hazardous
ICU	1	$25,000.00	$25,000.00	Allowance	Instrumentation
ICU	1	$2,500.00	$2,500.00	Apron	Lead, Allowance
ICU	1	$440.09	$440.09	Board	Patient Transfer Device
ICU	1	$150.75	$150.75	Bracket	Patient Transfer Device, Wall Mount
ICU	2	$40.03	$80.06	Bracket	Canister, Suction, Wall Mount
ICU	1	$307,400.00	$307,400.00	X-Ray Unit, C-Arm	Mobile

ICU	2	$65.92	$131.84	Flowmeter	Oxygen
ICU	1	$58.71	$58.71	Flowmeter	Air
ICU	1	$73.00	$73.00	Dispenser, Glove	Triple Box
ICU	1	$195.67	$195.67	Hamper	Linen
ICU	4	$907.00	$3,628.00	Pump, Infusion	Single
ICU	1	$475.00	$475.00	Stand, IV	w/Support
ICU	1	$6,400.00	$6,400.00	Light, Exam/Procedure	Single, Ceiling
ICU	1	$989.27	$989.27	Stand, Mayo	Foot-Operated
ICU	1	$28,206.00	$28,206.00	Dispenser, Medication	Auxiliary
ICU	1	$5,892.00	$5,892.00	Dispenser, Medication	Lock Module
ICU	1	$30,115.00	$30,115.00	Dispenser, Medication	Host (Main)
ICU	1	$25,115.00	$25,115.00	Dispenser, Medication	Host (Main)
ICU	1	$895.00	$895.00	Pump, Infusion	Controller, Modular
ICU	1	$4,477.00	$4,477.00	Monitor, Physiologic	Vital Signs, w/Stand
ICU	1	$5,613.00	$5,613.00	Monitor, Physiologic	Vital Signs
ICU	1	$32,000.00	$32,000.00	Monitor, Physiologic	Bedside, Critical Care, With Mobile Stand
ICU	1	$1,949.99	$1,949.99	Cart, Procedure	General
ICU	2	$230.00	$460.00	Rack	Apron, Wall Mount
ICU	1	$5,600.00	$5,600.00	Refrigerator	Medical Grade, Undercounter
ICU	2	$750.99	$1,501.98	Regulator	Suction, Intermittent/Continuous
ICU	1	$758.00	$758.00	Stool	Exam, Cushion-Seat
ICU	1	$9,325.00	$9,325.00	Stretcher	Procedure, C-arm
ICU	1	$9,325.00	$9,325.00	Stretcher	Procedure, C-arm
ICU	1	$862.27	$862.27	Table, Instrument	45-48 inch
ICU	1	$28,900.00	$28,900.00	Video System	Endoscopic
ICU	1	$3,794.99	$3,794.99	Waste Disposal	Pharmaceutical, Secure
ICU	1	$201.00	$201.00	Waste Disposal	Pharmaceutical, Secure, Wall
ICU	1	$70.90	$70.90	Waste Can	32-40 Gallon
ICU	1	$70.90	$70.90	Waste Can	Bio-Hazardous, 32-55 Gallon
ICU	1	$516.04	$516.04	Waste Can	Bio-Hazardous
ICU	1	$714.00	$714.00	Cart / Truck	Linen, Bulk
ICU	1	$73.00	$73.00	Dispenser, Glove	Triple Box
ICU	1	$321.06	$321.06	Waste Can	Roll Out
ICU	1	$354.30	$354.30	Waste Can	Bio-Hazardous, 32-55 Gallon
ICU	1	$73.00	$73.00	Dispenser, Glove	Triple Box
ICU	1	$195.67	$195.67	Hamper	Linen
ICU	1	$212.36	$212.36	Waste Can	44-55 Gallon
ICU	1	$516.04	$516.04	Waste Can	Bio-Hazardous
ICU	1	$19,000.00	$19,000.00	Electrocardiograph (ECG)	Interpretive
ICU	20	$907.00	$18,140.00	Pump, Infusion	Single
ICU	3	$475.00	$1,425.00	Stand, IV	w/Support
ICU	5	$895.00	$4,475.00	Pump, Infusion	Controller, Modular
ICU	2	$98,600.00	$197,200.00	Pump	Balloon, Intra-Aortic
ICU	1	$7,000.00	$7,000.00	Shelving	Allowance, Supply, High Density (Movable)
ICU	1	$15,000.00	$15,000.00	Shelving	Allowance, Supply, High Density (Movable)
ICU	1	$17,540.00	$17,540.00	Ultrasound, Imaging	Urology
ICU	1	$72,000.00	$72,000.00	Ultrasound, Imaging	Multipurpose
ICU	3	$217.00	$651.00	Cart, Utility	Stainless
ICU	1	$125,000.00	$125,000.00	X-Ray Unit	Mobile, Digital
ICU	2	$49.00	$98.00	Cart, Cylinder	D&E, Single
ICU	1	$223.00	$223.00	Cart, Cylinder	D&E, Multi
ICU	1	$283.00	$283.00	Cart, Cylinder	D&E, Multi
ICU	2	$21,706.76	$43,413.52	Ventilator	BiPAP
ICU	2	$56,106.00	$112,212.00	Ventilator	Adult / Pediatric
ICU	1	$10,000.00	$10,000.00	Allowance	Equipment, Physical Therapy
ICU	1	$386.65	$386.65	Cart, Cylinder	D&E, Multi
ICU	1	$340.00	$340.00	Cart, Cylinder	D&E, Multi
ICU	1	$16,800.00	$16,800.00	Dialysis Unit	General
ICU	1	$140,000.00	$140,000.00	Respirator	Allowance
ICU	1	$856.00	$856.00	Shelving	Wire, Chrome, 48 inch
ICU	1	$1,117.00	$1,117.00	Cart, Supply	Chrome, 36 inch
ICU	1	$217.00	$217.00	Cart, Utility	Stainless
ICU	2	$33,837.00	$67,674.00	Ventilator	Adult / Pediatric
ICU	1	$1,200.00	$1,200.00	Shelving	Wire, Allowance
ICU	1	$834.00	$834.00	Shelving	Wire, Chrome, 60 inch
ICU	1	$1,109.00	$1,109.00	Shelving	Wire, Chrome, 72 inch
ICU	1	$1,302.80	$1,302.80	Cart, Supply	Chrome, 48 inch
ICU	1	$100,000.00	$100,000.00	Allowance	Miscellaneous

Schedule 13 B-2. Medical/Center Director and Transfer Agreements

NOT APPLICABLE

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

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

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

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

NOT APPLICABLE

Schedule 13 B-3. AMBULATORY SURGERY CENTERS ONLY - Physician Commitments
Upload a spreadsheet or chart as an attachment to this Schedule of all practitioners, including surgeons, dentists, and podiatrists who have expressed an interest in practicing at the Center. The chart must include the information shown in the template below.
Additionally, upload copies of letters from each practitioner showing the number and types of procedures he/she expects to perform at the Center per year.

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

3

New York State Department of Health
Certificate of Need Application

Schedule 13 D: Annual Operating Revenues

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

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

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

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

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

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

Required Attachments

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

MOUNT SINAI HOSPITAL – MOUNT SINAI HOSPITAL OF QUEENS

Depreciation Schedule

Mount Sinai Hospital – Mount Sinai Hospital of Queens

Construct a new 21-Bed Intensive Care Unit

CALCULATION OF DEPRECIATION

	Amount	Depreciation Life (in Years)	Depreciation Amount
Moveable Equipment:	3,898,411	7	556,916
Leasehold Improvements/Other:	23,193,755	25	927,750
Total:	**$27,092,166**		**$1,484,666**

Schedule 16 A. Hospital Program Information

See "Schedules Required for Each Type of CON" to determine when this form is required.

Instructions: Briefly indicate how the facility intends to comply with state and federal regulations specific to the services requested, such as cardiac surgery, bone marrow transplants. For clinic services, please include the hours of service for each day of operation, name of the hospital providing back-up services (indicating the travel time and distance from the clinic) and how the facility intends to provide quality oversight including credentialing, utilization and quality assurance monitoring.

Mount Sinai Hospital – Mount Sinai Hospital of Queens (MSQ), a division of The Mount Sinai Hospital, is submitting this Administrative Review Certificate of Need Application that seeks approval to construct a new 21-bed Intensive Care Unit (ICU) in space currently being used for storage and a small conference center on the 6th floor of MSQ's main hospital campus building, located at 25-10 30th Avenue, Long Island City (Queens County), New York 11102. MSQ currently operates an eight-(8)-bed ICU that is outdated, undersized and has been operating between 81% and 87% occupancy for the past several years, which is above the 65-75% average that is considered optimal for ICU beds.

The Quality Assurance (QA) Program for the ICU will continue to be administered by Nazia Mashriqi, M.D., who currently serves as the Intensive Care Unit Director, at MSQ. All administrative aspects of the services to be provided in this project will be directed by an individual who is qualified for such duties by education and experience.

To ensure that care and services are appropriate to an individual's needs, MSQ will continue to use a comprehensive utilization review and monitoring program for the services provided. The appropriate utilization of services will be monitored through the QA/PI Program, under the supervision of the Medical Director.

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

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

For Hospital-Based -Ambulatory Surgery Projects:
Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category
NOT APPLICABLE

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

Number and Type of Operating Rooms: **NOT APPLICABLE**

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

Number and Type of Procedure Rooms: **NOT APPLICABLE**

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

Schedule 16 B. Community Need

See "Schedules Required for Each Type of CON" to determine when this form is required.

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

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

The primary service area for this project is Queens County.

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

Please refer to the Health Equity Impact Assessment that is included with this Application, which contains a thorough analysis of the quantitative and qualitative description of the population to be served.

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

MSQ's existing eight-(8)-bed ICU is outdated, too small and has been operating between 81% and 87% occupancy for the past several years, as depicted in the chart below—well above the optimal range of 65-75% for intensive care units.

	2021	2022	2023	2024	2025
ICU Cases	410	515	657	684	623
ICU Days	2,543	2,380	2,416	2,536	2,370
Avg LOS	6.20	4.62	3.68	3.71	3.80
Existing ICU Beds	8	8	8	8	8
Total Bed Days (365 days/Year)	2,920	2,920	2,920	2,920	2,920
ICU Occupancy	87.1%	81.5%	82.7%	86.8%	81.2%

MSQ plans to build a new 21-bed ICU by adding 13 ICU beds to its operating certificate, raising the total certified beds from 228 to 241. The proposed ICU will be constructed on the 6th floor of the main hospital building (25-10 30th Avenue, Long Island City, Queens County, New York 11102), utilizing space now used for storage and a conference center. After completion of this project, MSQ will relocate some of its existing Medical/Surgical beds to the area currently occupied by the eight-(8)-bed ICU. This relocation aims to enhance the efficiency and operations of the Medical/Surgical beds overall. The new ICU will also include a Class 2 Procedure room to provide fluoroscopy-guided peripherally inserted central catheter (PICC) line placements, central line placements and dialysis catheter placements.

Currently, the limited ICU capacity restricts MSQ's service expansion, its ability to manage more complex cases and treatment of critically ill patients. Furthermore, MSQ experiences backlogs and boarding in the emergency department (ED), as patients needing telemonitoring cannot always be transferred to the ICU. This leads to further

capacity challenges and inconveniences for patients, families and staff. Additionally, many ICU-eligible patients are transferred to other hospitals in the Mount Sinai Health System, especially The Mount Sinai Hospital, causing additional strain there—where ICU occupancy often exceeds 95%. In recent years, more than 125 ICU-eligible patients per year have been transferred out of MSQ.

With increasing patient acuity and frequent ICU crowding, expanding and modernizing the ICU at MSQ is essential for ensuring timely access to critical care, reducing ED congestion and improving overall patient flow. The new ICU will also support more complex surgeries, leading to better outcomes and keeping advanced care accessible within the community. Nearly tripling ICU capacity will reduce ED boarding, decrease patient transfers out of Queens County and strengthen surge preparedness. Most importantly, expanded critical care capacity will allow MSQ to grow its surgical program and deliver high-acuity care locally.

Increased ICU capacity at MSQ is also crucial for maintaining resources across the entire Mount Sinai Health System, enhancing convenience and experience for patients, families, and caregivers, and providing readiness for crisis situations—lessons learned during the COVID-19 pandemic. Although MSQ successfully managed the initial COVID-19 surge in early 2020 and met surge requirements, using non-traditional spaces like recovery bays, hallways and common areas was not ideal. This project ensures better preparedness for future pandemics.

With this expansion, MSQ expects to treat sicker patients in its ICU, resulting in a higher case mix and longer average stays. Volume is also anticipated to grow as fewer patients will need to be transferred out as the Hospital's services broaden. Alleviating ED bottlenecks and capacity issues will further support this growth. According to the projections below, by Year 3, MSQ's ICU occupancy should reach optimal levels, enabling the hospital to still handle surges while maintaining high-quality care.

	2025	Year 1	Year 2	Year 3	Year 4	Year 5
ICU Cases	623	758	836	913	991	1,069
ICU Days	2,370	3,881	4,280	4,675	5,074	5,473
Avg LOS	3.80	5.12	5.12	5.12	5.12	5.12
Existing ICU Beds	8	21	21	21	21	21
Total Bed Days (365 days/Year)	2,920	7,665	7,665	7,665	7,665	7,665
ICU Occupancy	81.2%	50.6%	55.8%	61.0%	66.2%	71.4%

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

The approval of this Application is necessary to sustain and expand the high level of services provided at MSQ, as well as to continue the Hospital's mission of providing healthcare services to all individuals of the service area.

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

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

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

The population to be served currently receives the proposed services at MSQ. Additionally, many ICU eligible patients are being transferred to other Mount Sinai Health System hospitals in other counties (primarily The Mount Sinai Hospital). Please refer to Question No. 3 above for additional information.

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

Please refer to Question No. 3 above.

ONLY for Hospital Applicants submitting Full Review CONs

NOT APPLICABLE

Non-Public Hospitals

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

ONLY for Hospital Applicants submitting Full Review CONs

NOT APPLICABLE

Public Hospitals

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

N/A

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

N/A

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

N/A

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

N/A

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

NOT APPLICABLE

C. Impact of CON Application on Hospital Operating Certificate

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

TABLE 16C-1 AUTHORIZED BEDS

LOCATION:
NOT APPLICABLE
(Enter street address of facility)

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

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

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

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

NOT APPLICABLE

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TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:
NOT APPLICABLE
(Enter street address of facility)

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

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

NOT APPLICABLE

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

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

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

NOT APPLICABLE

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

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

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

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

END STAGE RENAL DISEASE (ESRD) NOT APPLICABLE

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

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

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

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

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

NOT APPLICABLE

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

NOT APPLICABLE

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

NOT APPLICABLE

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

NOT APPLICABLE

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

NOT APPLICABLE

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date: 2024		1st Year Start date: 2028		3rd Year Start date: 2030	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
AIDS	-	-	-	-	-	-
BONE MARROW TRANSPLANT	-	-	-	-	-	-
BURNS CARE	-	-	-	-	-	-
CHEMICAL DEPENDENCE - DETOX	-	-	-	-	-	-
CHEMICAL DEPENDENCE - REHAB	-	-	-	-	-	-
COMA RECOVERY	-	-	-	-	-	-
CORONARY CARE	258	1,555	258	1,555	258	1,555
INTENSIVE CARE	546	6,361	681	7,934	836	9,740
MATERNITY	6,139	14,708	6,139	14,708	6,139	14,708
MED/SURG	47,105	323,827	47,105	323,827	47,105	323,827
NEONATAL CONTINUING CARE	-	-	-	-	-	-
NEONATAL INTENSIVE CARE	606	15,245	606	15,245	606	15,245
NEONATAL INTERMEDIATE CARE	-	-	-	-	-	-
PEDIATRIC	3,461	19,001	3,461	19,001	3,461	19,001
PEDIATRIC ICU	-	-	-	-	-	-
PHYSICAL MEDICINE & REHABILITATION	804	16,598	804	16,598	804	16,598
PRISONER	-	-	-	-	-	-
PSYCHIATRIC	879	16,510	879	16,510	879	16,510
RESPIRATORY	-	-	-	-	-	-
SPECIAL USE	-	-	-	-	-	-
SWING BED PROGRAM	-	-	-	-	-	-
TRANSITIONAL CARE	-	-	-	-	-	-
TRAUMATIC BRAIN-INJURY	-	-	-	-	-	-
OTHER (Newborn)	5,729	13,853	5,729	13,853	5,729	13,853
TOTAL	65,527	427,658	65,662	429,231	65,817	431,037

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

Schedule 16 F. Facility Access **NOT APPLICABLE**

See "Schedules Required for Each Type of CON" to determine when this form is required.

Complete Table 1 to indicate the method of payment for inpatients and for inpatients and outpatients who were transferred to other health care facilities for the calendar year immediately preceding this application.
Start date of year for which data applies (m/c/yyyy):

Table 1. Patient Characteristics	Total Number of Inpatients	Number of Patients Transferred		
		Inpatient	OPD	ER
Payment Source				
Medicare				
Blue Cross				
Medicaid				
Title V				
Workers' Compensation				
Self Pay in Full				
Other (incl. Partial Pay)				
Free				
Commercial Insurance				
Total Patients				

Complete Table 2 to indicate the method of payment for outpatients.

Table 2. Outpatient Characteristics	Emergency Room		Outpatient Clinic		Community MH Center	
	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions
Primary Payment Source						
Medicare						
Blue Cross						
Medicaid						
Title V						
Workers' Compensation						
Self Pay in Full						
Other (incl. Partial Pay)						
Free						
Commercial Insurance						
Total Patients						

A. Attach a copy of your discharge planning policy and procedures.

B. Is your facility a recipient of federal assistance under Title VI or XVI of the Public Health Service? Act (Hill-Burton)?

Yes ☐ No ☐

If yes, answer the following questions and attach the most recent report on Hill-Burton compliance from the Federal Department of Health and Human Services.

1. Is your facility currently obligated to provide uncompensated service under the Public Health Service Act?
Yes ☐ No ☐

If yes, provide details on how your facility has met such requirement for the last three fiscal years - including notification of the requirement in a newspaper of general circulation. Also, list any restricted trusts and endowments that were used to provide free, below-cost or charity care services to persons unable to pay.

2. With respect to all or any portion of the facility which has been constructed, modernized, or converted with Hill-Burton assistance, are the services provided therein available to all persons residing in your facility's service area without discrimination on the basis of race, color, national origin, creed, or any basis unrelated to an individual's need for the service or the availability of the needed service in the facility?

Yes☐ No☐

If no, provide an explanation.

3. Does the facility have a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility?

Yes ☐ No ☐

4. Do Medicaid beneficiaries have full access to all of your facility's health services?

Yes ☐ No ☐

If no, provide a list of services where access by Medicaid beneficiaries is denied or limited.

NOT APPLICABLE