INSTRUCTIONS FOR COMPLETION OF

FULL REVIEW CERTIFICATE OF NEED APPLICATION FOR LONG TERM CARE FACILITIES: GENERAL LONG TERM CARE BEDS; SPECIALIZED LONG TERM CARE BEDS

SECTION I. GENERAL REQUIREMENTS

1. CERTIFICATE OF NEED

A. Application for general and/or specialized long term care beds may only be submitted in response to a Certificate of Need call issued by the Department and published in the New Jersey Register.

B. SUBMISSION - NEW JERSEY DEPARTMENT OF HEALTH

Submit one completed application in electronic media and 35 paper copies of the application forms and all required documentation to:

Mailing Address:
New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
P. O. Box 358
Trenton, NJ 08625-0358

Overnight Services (DHL, FedEx, UPS):
New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
120 South Stockton Street, 3rd Floor
Trenton, NJ 08608-1832

C. SIGNATURE

All applications must be signed by the applicant, that is, the current or proposed licensed operator of the health care facility.

D. FILING FEE

All applications must be accompanied by a certified check, cashier's check, or money order made payable to *"Treasurer, State of New Jersey."* Failure to submit the appropriate fee at the time of filing will result in the application not being accepted for processing.

FEE SCHEDULE:

Total Project Cost (TPC)	**Fee Required**
$1,000,000 or Less	$7,500
Greater Than $1,000,000	$7,500 + 0.25% of TPC

E. COMPLETENESS

1. ALL QUESTIONS REQUIRE AN ANSWER AND ALL SCHEDULES MUST BE COMPLETELY FILLED OUT.

2. Certificate of Need forms must be filed in sequential order. Do not renumber pages.

3. Identify each response in Section II by question number and respond in sequential order. All additional supporting documentation must be attached to the back of the Certificate of Need Application form after the exhibits, in a Section titled "Appendix."

4. All exhibits required in Section III (Required Documents) must be identified as

noted herein and attached to the back of the Certificate of Need Application form and referenced to the corresponding item in Section III.

5. Only complete applications will be processed [N.J.A.C. 8:33-4.5(a)]. Failure to submit all required information and documentation and/or to follow the steps outlined herein when the Certificate of Need is filed may result in a determination that the application is incomplete and, as such, may not be accepted for processing.

6. All cost estimates for new construction and/or renovations should be submitted in those dollars which would be needed to complete the project over the anticipated period of construction, assuming that construction was to begin at the time of your Certificate of Need submission.

F. MODIFICATION

No application may be altered or modified by an applicant after the deadline date for application submission. Additional information shall be permitted only in direct response to written questions submitted to the applicant by the New Jersey Department of Health.

2. STATE HEALTH PLANNING

A. Applicants should contact the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure (609-292-5960) to obtain need projections for long term care. Such projections are also contained in the Call Notice published in the New Jersey Register.

B. The Long Term Care Policy Manual (N.J.A.C. 8:33H) may be obtained from the Department's website at http://www.nj.gov/health/healthfacilities/forms.shtml.

3. LICENSING

Licensing manuals for long term care facilities may be obtained from the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure (609-633-9042) or obtained from the Department's website at http://www.nj.gov/health/healthfacilities/forms.shtml.

4. FINANCIAL

Applicants should contact the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure (609-633-9042) with any questions with regard to completing the financial requirements portions of the application.

5. CONSTRUCTION

Applicants should contact the New Jersey Department of Community Affairs (609-633-8151) to obtain information regarding construction requirements.

SECTION II. REQUIREMENTS FOR COMPLETION OF CERTIFICATE OF NEED APPLICATION

1. STATE CERTIFICATE OF NEED REQUIREMENTS - Provide in Section L, Narrative

A. DESCRIPTION

Provide a brief description of the programs, services and physical environment that will be offered at the proposed facility, highlighting any unique aspects of the project.

B. ETHNIC MIX

Describe the ethnic mix of the service area within which the proposed facility will be located, and identify any population sub-groups that are under-served with regard to long term care and related services. Explain how access to care for ethnic minorities and under-served groups will be improved by the proposed project and how the unique needs of individuals from these groups will be accommodated at this facility.

C. LONG TERM CARE POLICY MANUAL

Address all applicable certificate of need requirements contained in the Long Term Care Policy Manual (N.J.A.C. 8:33H). Indicate how the proposed project will comply with each applicable requirement, or provide a justification for why the project does not comply with one or more of the requirements.

In completing the Project Narrative, it is only necessary to address those requirements that are applicable to your application. While it is the applicant's responsibility to assure that all pertinent requirements are addressed, applicants for the following types of projects should take special note of these specific sections of the Policy Manual and address applicable sections:

Type of Project	Policy Manual Requirements
General Long Term Care Facility	N.J.A.C. 8:33H 1.1, 1.9, 1.13-1.18
Specialized Long Term Care Facility	N.J.A.C. 8:33H 1.1, 1.5, 1.6, 1.9, 1.13-1.18
Restricted Admission Facility	N.J.A.C. 8:33H 1.1, 1.11, 1.13-1.18

D. ACREAGE AND ZONING

Specify the acreage and zoning status of the proposed site. If the facility is an existing structure, describe the building's layout and indicate its age. Identify all land use/zoning approvals that must be obtained before this project can be implemented, if approved. Provide a timetable for obtaining these approvals.

E. STATUTORY CRITERIA

In Section L, each applicant must address the following statutory criteria (see N.J.S.A. 26:2H-8):

1. The availability of facilities or services which may serve as alternatives or substitutes.
2. The need for special equipment and services in the area.
3. The possible economics and improvements in services to be anticipated from the operation of joint central services.
4. The adequacy of financial resources and sources of present and future revenues.
5. The availability of sufficient manpower in the several professional disciplines.

2. CONSTRUCTION REQUIREMENTS

A. All cost estimates for new construction and/or renovations, should be submitted in those dollars which would be needed to complete the project over the anticipated period of construction, assuming that construction was to begin at the time of your Certificate of Need submission. Please provide in Section B of the application.

B. Provide proposed total "building gross square footage" of new construction. Indicate building's proposed design, number of stories and construction type. Please provide in Section A6. Submit architectural sketches if available.

C. Projects involving complete demolition of a structure(s) should indicate structure's total cubic feet, number of stories, gross square footage per floor and construction type. Identify demolition cost estimate as a separate line item in Section L, Narrative.

D. Provide total square footage of area proposed for renovations in Section A6. Indicate the current or most recent use and physical layout of the space. Provide a summary description of the renovations proposed and/or required, acknowledging all applicable construction trades.

E. Provide description and/or listing of equipment items inclusive of the "fixed equipment not in construction contracts" line item(s) cost estimates.

F. Projects with more than one area affected by renovations must complete Schedule A. Utilize a separate line item for each area on a given floor/wing and for any change in use of an existing area. Square footage and renovation hard cost totals of this form should reconcile with those amounts indicated on pages 2, 3, 8 and 9 of the Certificate of Need Application. Account for all displaced areas, relocations and vacated areas, even if there are no associated renovation costs. Indicate how this information was established.

G. Any applicant who is proposing a vertical expansion (additional floor(s) to an existing building) shall submit a certification, from an appropriate design professional, that the existing structure/affected building shall comply with the current code requirements for increase in size (floor area and/or height) and earthquake loads.

3. LICENSING REQUIREMENTS

A. One hundred percent of the ownership and operation of the proposed facility, service or equipment must be accounted for in the certificate of need application. Each and every principal involved in the proposal must be identified by name, home address and percentage of interest, except that if the ownership and operation is a publicly held corporation, each and every principal who has a ten percent or greater interest in the corporation must be identified by name, home address and percentage of interest. Where a listed principal has an ownership or operating interest in another health care facility, in this or any other state, identification of the principal(s), the health care facilities in which they have an ownership or operating interest, and the nature and amount of each interest must be specified. Please provide this information in Sections A10 and A11.

B. If the applicant is a registered corporation, the name and address of the registered agent must be identified in the application. Please provide in Section A12.

C. If a management company will be hired, the name and address of all principals in the management company must be identified and, if the certificate of need if approved, prior to licensure, a copy of the management agreement must be submitted to the Certificate of Need and Acute Care Licensure Program and the Division of Long Term Care Systems. Any change in management subsequent to certificate of need approval must be reported to the Division of Long Term Care Systems.

D. The proposed licensed operator of the proposed facility, service, or equipment shall file and sign the application.

4. CERTIFICATE OF NEED REQUIREMENTS - OWNERSHIP, TRACK RECORD AND ACCESS ISSUES.

A. In accordance with 8:33-4.4(a), an applicant must document in the application that he/she owns the site where the facility, service, or equipment will be located, or has an ownership or lease option for such site, which option is valid at least through the certificate of need processing period. A duly executed copy of the deed, option or lease agreement for the site must be submitted with the certificate of need application and include identification of site, terms of agreement, date of execution and signature of all parties to the transaction. If the site is optioned or leased by the applicant, a copy of the deed held by the current owner is required at the time of filing.

B. In accordance with 8:33-4.10(d), each applicant for certificate of need shall demonstrate character and competence, quality of care, and an acceptable track record of past and current compliance with State licensure requirements in all states in which the applicant is licensed to operate, applicable Federal requirements, and New Jersey certificate of need requirements. Track record reports from other states must be on the letterhead of the other states and must accompany the Certificate of Need application. The report must indicate compliance with both Federal Certification and State Licensure requirements, as applicable. Additionally, in Section A8, indicate the performance of the applicant in meeting its obligation under any previously approved certificate of need in New Jersey, including full compliance with the cost and scope as approved, as well as all conditions of approval.

C. The certificate of need criteria at N.J.A.C. 8:33-4.9 and 4.10 must be specifically addressed.

D. If the facility is an existing licensed health care facility, the name of the facility as it appears on the license must be used in the certificate of need application.

SECTION III. REQUIRED DOCUMENTS

1. CERTIFICATE OF NEED

A. PROOF OF INCORPORATION

If the owner and/or operator is a corporation, the corporation must be an existing registered corporation and proof of incorporation must be submitted with the application.

B. PARTNERSHIP AGREEMENT

If the owner and/or operator is a partnership, a copy of any executed partnership agreement must be submitted with the application.

C. Only complete applications will be processed [N.J.A.C. 8:33-4.5(a)]. Failure to meet the certificate of need filing requirements identified in N.J.A.C. 8:33 and this application form will result in the application being declared incomplete and removed from the review process. There will be no exceptions to this requirement.

2. FINANCIAL

A. FEASIBILITY

1. If any studies (i.e., Financial Feasibility Study or Facility Planning Studies) were done to help the facility determine its need and/or financial feasibility, and are referenced in the application, a copy must be included as part of the application for review. However, such studies are not required.

2. If financial resources for the project are monies from a grant, provide the Department with a copy of the budget submitted when the grant application was made. The status of the grant, as of the date of Certificate of Need application, must be reported on the forms.

3. If financial resources for the project and/or monies for the operational budget are to be provided by a governmental agency, a statement indicating the intention of the agency to provide the funds must accompany the Certificate of Need application.

4. If financial resources for the project and/or monies for the operational budget are to be a secondary responsibility of a parent or a separate corporation that has a controlling interest, a letter must accompany the Certificate of Need application stating the intention of the corporation to underwrite the financial resources and/or operating budget.

5. The specific source and documentation verifying the availability of the cash equity contribution must be submitted with the application. Acceptable forms of verification include savings statements, a letter from a bank officer stating sufficient funds have been escrowed for the equity contribution, land appraisal if the appraised value of land is included in the project cost and the land is not subject to any liens.

B. CERTIFIED FINANCIAL STATEMENT

All applications from existing providers must be accompanied by a copy of the latest certified financial statements. The certified report must include the following:

1. Balance Sheet

2. Statement of Income and Expenses, with supporting schedules

3. Statement of Changes in Financial Position

4. Notes to the Statements

5. Auditor's Letter

If an existing provider applicant does not normally engage outside auditors to certify its financial statements, it may provide, in lieu of the above:

1. Unaudited financial statements from an independent source to include the items listed above for a certified statement; and/or

2. In-house financial statements drawn up and including the items listed above for a certified statement.

C. OTHER

1. All applications must address the financial requirements identified at 8:33-4:10(b). Use additional sheets if necessary.

2. Report all expense and revenue data in current dollars (dollars of year certificate of need is submitted).

3. Include an estimate of fringe benefits in all salary projections.

4. If the project is to be financed, provide a "source and uses of funds" statement. This statement must be from an investment banker or accountant.

5. The schedule of estimated charges and income information provided in items 2 and 3 of Sections E through H (pages 10 through 13 of the application) should be based on the estimated revenue to be collected for each payer.

3. PLANNING

COMMUNITY SUPPORT

Where a facility initiates a new program or service or expands an existing one, it may support its application for a Certificate of Need by providing written documentation of existing working relationships or of plans to develop working relationships with other providers in the area.

4. MEDICAID REIMBURSEMENT

Please be advised that Certificate of Need approval of general and/or specialized long term care beds shall not be construed to imply that the approved applicant will subsequently be approved as a Medicaid provider or to participate in the Medicaid Program in any manner. Any applicant approved for participation in the Medicaid Program for long term care services shall also simultaneously become Medicare Certified (for all long term care bed categories for which the facility is licensed) and shall maintain such dual certification for as long as the facility participates in the Medicaid Program. Additionally, all approved applicants shall admit all individuals for whom they have the ability to provide care regardless of payer source. Each applicant is required to acknowledge this in the Narrative section of this application.

New Jersey Department of Health

APPLICATION - FULL REVIEW CERTIFICATE OF NEED

LONG TERM CARE FACILITIES: GENERAL LONG TERM CARE BEDS;
SPECIALIZED LONG TERM CARE BEDS

FOR STATE USE ONLY		
Cycle	Application Number	
Fee: Amount Due	Fee: Amount Received	Date Received

Name of Facility	Telephone Number
Street Address of Facility	
Municipality/Township	Email Address
County	Zip Code
Name of Owner/Applicant (Operator/License Holder)	Type of Ownership
Name of Responsible Officer	
Street Address of Owner/Applicant	
City, State, Zip Code	
Telephone Number Business: Home:	
Name of Facility Representative	Telephone Number
Street Address of Facility Representative	
City, State, Zip Code	
Name of Consultant	Telephone Number
Street Address of Consultant	Email Address
City, State, Zip Code	

Name of Facility

A. Project Summary

1. Construction (check all that apply):
   - ☐ New Construction
   - ☐ Modernization/Renovation
   - ☐ Addition

2. Beds (check all that apply):
   - ☐ New Bed-Related Facility
   - ☐ Addition
   - ☐ Deletion of Beds Within Category
   - ☐ Conversion
   - ☐ Reduction
   - ☐ No Change in Beds

3. Health Care Services (check all that apply):
   - ☐ New Service
   - ☐ Expansion of Service

4. Summary of Project Cost:

Capital Cost	
Financing Cost	
Total Project Cost	
Equity Contribution (in dollars)	
Equity Contribution as a Percent of Total Project Costs	
Method of Financing	

5. Number of Licensed and Proposed Beds and/or Units:

Bed Category	Licensed Beds	CN App'd But Not Licensed Beds	Proposed New Beds	Proposed Decrease In Beds	Total Beds After Project Completion
General Long Term Care					
Specialized Long Term Care (Ventilator)					
Specialized Long Term Care (Behavior Management)					
Specialized Long Term Care (Pediatric)					
Totals					

6. Summary of Construction/Lease Cost:

Type:	Gross Square Feet	Construction Cost	Construction Cost/Square Foot	Construction Cost/Bed
New Construction				
General Long Term Care				
Specialized Long Term Care (Ventilator)				
Specialized Long Term Care (Behavior Management)				
Specialized Long Term Care (Pediatric)				
Total New Construction				

Name of Facility

6. Summary of Construction/Lease Cost, Continued:

Renovation				
General Long Term Care				
Specialized Long Term Care (Ventilator)				
Specialized Long Term Care (Behavior Management)				
Specialized Long Term Care (Pediatric)				
Total Renovation				
Total New and Renovation				

7. Identify other health care facilities owned, operated or managed (in any state) by each of the principals of the ownership/operation entity. If out-of-state facilities are included, a track record request (see Appendix A for an example of a request letter) from the state agency which licenses those facilities must be filed with the certificate of need application. This report must include any enforcement action taken against the facility(ies) within the year proceeding application submission. If none, so state.

Name of Facility	Location	Number of Beds

8. If any licensed facilities have been identified by the applicant in response to Item A. 7., provide a description of how each facility is complying with its conditions of certificate of need approval for any facilities licensed in New Jersey (e.g., Medicaid utilization requirements). If any facility is not in compliance with its conditions of certificate of need approval, so state and provide an explanation. (If necessary, attach a separate page and identify as Item A. 8.).

9. Does the applicant for the proposed project possess any Certificate of Need for health care facilities or portions thereof that are not yet constructed, licensed or operational? If yes, please identify by Certificate of Need number. Include a detailed account of the status. Provide a description of the progress that is being made toward implementing these projects. If the applicant does not intend to implement any previously approved project or any portion thereof, please explain why. (If necessary, attach a separate page and identify as Item A. 9.).

Name of Facility

10. Identify the corporate or partnership name of the owner. Identify one hundred percent of the ownership of the proposed facility or service. Each and every principal involved in the ownership shall be identified by name, home address and percentage of interest. If the ownership is a publicly held corporation, each and every principal who has a 10 percent or greater interest in the corporation shall be identified by name, home address and percentage of interest. Please provide your response below. Use attachment only if the information exceeds the allotted space. Provide any additional information on a separate page and attach to page 4 of the certificate of need application.

Name of Corporation/Partnership: _____

Name of Principal	Home Address	% of Interest

11. Identify the corporate or partnership name of the operator. Identify one hundred percent of the operator of the proposed facility or service. Each and every principal involved in the operation shall be identified by name, home address and percentage of interest. If the ownership of the operative entity is a publicly held corporation, each and every principal who has a 10 percent or greater interest in the corporation shall be identified by name, home address and percentage of interest. Please provide your response below. Use attachment only if the information exceeds the allotted space. Provide any additional information on a separate page and attach to page 4 of the certificate of need application.

Name of Corporation/Partnership: _____

Name of Principal	Home Address	% of Interest

12. Name and Address of Registered Agent: _____

Name of Facility

PROJECT SUMMARY

A written summary of your project is required. Please do so on Pages 5 through 7 of the Certificate of Need Application form. The summary must be comprehensive and not exceed three pages.

Name of Facility

PROJECT SUMMARY, Continued

Name of Facility

PROJECT SUMMARY, Continued

Name of Facility

B. DETAILED PROJECT COSTS

Project costs should be submitted in those dollars which would be needed to complete the project over the anticipated period of construction if construction were to begin at the time of submission of the Certificate of Need proposal to the Department.

	General Long Term Care	Specialized Long Term Care (Ventilator)	Specialized Long Term Care (Behavior Management)	Specialized Long Term Care (Pediatric)
1. Capital Costs				
All Studies and Surveys				
Architect and Engineer Fees				
Demolition				
Renovations				
New Construction				
Fixed Equipment Not in Construction Contracts				
Major Movable Equipment				
Purchase of Land				
Purchase of Building(s)				
Other (Specify):				
_____				
_____				
Total Capital Costs				
2. Financing Costs *				
Capitalized Interest				
Debt Service Reserve Funds				
Other Financing Costs**				
Total Financing Costs				
Total Project Cost (1 plus 2)				

*Provide details of financing in Section D.

**Include fees assessed by any financing agency, bond counsel fees, trustees bank fees and/or other costs related to sale of bonds)

Name of Facility

C. PROPOSED METHOD OF FINANCING THE TOTAL PROJECT COST:

For purposes of Certificate of Need review, equity shall mean a non-operating asset contribution which will reduce the size of the total debt. It may include cash, other liquid assets, and the fair appraised market value of land owned by an applicant which is the viable site for the proposed project. A minimum of ten percent (10%) of the total project cost, including all financing and carrying costs, must be available in the form of equity, as required at N.J.A.C. 8:34H-1.16(f).

1. Available Cash (provide verification) $ _____
2. Land _____
3. Other (Specify):

_____ _____

Total $ _____

D. MORTGAGE/LOANS/LEASE ARRANGEMENTS FOR THE PROJECT:

Lender/Lending Institution	Amount	Rate of Interest	Annual Payment	Maturity Date
_____	$ _____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	$ _____	_____	_____	_____

Name of Facility

E. 1. Statistics - General Long Term Care Beds
(Projections on all schedules are for the first two years of operation):

Item	Current *	1st Year Projections 20__	2nd Year Projections 20__
Number of Licensed Beds			
Percent of Occupancy			
Number of Patient Days			
Average Charge Per Patient Day			

2. Schedule of Estimated Charges – General Long Term Care Beds:

Bed Accommodation		Rate		Number of Beds In This Category
Single	$		per	
Double	$		per	
Three-Bed	$		per	
Four-Bed	$		per	

3. Revenue - General Long Term Care (use current dollars):

Revenue (Based on Above Statistics)	Patient Mix	1st Year Projection 20__	2nd Year Projection 20__
Room, Board and Routine			
Self-Pay			
Medicare			
Medicaid			
Other (Specify):			
Sub-Total			
Less: Allowance for Bad Debts			
Total			

* Last full year prior to application submission; if project changes the number of General Long Term Care beds, this page must be completed.

Name of Facility

F. 1. Statistics – Specialized Long Term Care (Ventilator) Beds
(Projections on all schedules are for the first two years of operation):

Item	Current *	1st Year Projections 20__	2nd Year Projections 20__
Number of Licensed Beds			
Percent of Occupancy			
Number of Patient Days			
Average Charge Per Patient Day			

2. Schedule of Estimated Charges – Specialized Long Term Care (Ventilator) Beds:

Bed Accommodation		Rate		Number of Beds In This Category
Single	$		per	
Double	$		per	
Three-Bed	$		per	
Four-Bed	$		per	

3. Revenue – Specialized Long Term Care (Ventilator) (use current dollars):

Revenue (Based on Above Statistics)	Patient Mix	1st Year Projection 20__	2nd Year Projection 20__
Room, Board and Routine			
Self-Pay			
Medicare			
Medicaid			
Other (Specify):			
Sub-Total			
Less: Allowance for Bad Debts			
Total			

* Last full year prior to application submission; if project changes the number of Specialized Long Term Care (Ventilator) Beds, this page must be completed.

Name of Facility

G. 1. Statistics - Specialized Long Term Care (Behavior Management) Beds
(Projections on all schedules are for the first two years of operation):

Item	Current *	1st Year Projections 20__	2nd Year Projections 20__
Number of Licensed Beds			
Percent of Occupancy			
Number of Patient Days			
Average Charge Per Patient Day			

2. Schedule of Estimated Charges – Specialized Long Term Care (Behavior Management) Beds:

Bed Accommodation		Rate		Number of Beds In This Category
Single	$		per	
Double	$		per	
Three-Bed	$		per	
Four-Bed	$		per	

3. Revenue - Specialized Long Term Care (Behavior Management) (use current dollars):

Revenue (Based on Above Statistics)	Patient Mix	1st Year Projection 20__	2nd Year Projection 20__
Room, Board and Routine			
Self-Pay			
Medicare			
Medicaid			
Other (Specify):			
Sub-Total			
Less: Allowance for Bad Debts			
Total			

* Last full year prior to application submission; if project changes the number of Specialized Long Term Care (Behavior Management) Beds, this page must be completed.

Name of Facility

H. 1. Statistics - Specialized Long Term Care (Pediatric) Beds
(Projections on all schedules are for the first two years of operation):

Item	Current *	1st Year Projections 20__	2nd Year Projections 20__
Number of Licensed Beds			
Percent of Occupancy			
Number of Patient Days			
Average Charge Per Patient Day			

2. Schedule of Estimated Charges – Specialized Long Term Care (Pediatric) Beds:

Bed Accommodation		Rate		Number of Beds In This Category
Single	$		per	
Double	$		per	
Three-Bed	$		per	
Four-Bed	$		per	

3. Revenue - Specialized Long Term Care (Pediatric) (use current dollars):

Revenue (Based on Above Statistics)	Patient Mix	1st Year Projection 20__	2nd Year Projection 20__
Room, Board and Routine			
Self-Pay			
Medicare			
Medicaid			
Other (Specify):			
Sub-Total			
Less: Allowance for Bad Debts			
Total			

* Last full year prior to application submission; if project changes the number of Specialized Long Term Care (Pediatric) Beds, this page must be completed.

Name of Facility

I. Operating Budget * - Projections for the first two full years of operation.

1. All facilities must prepare the budget projections for the operating expenses and for the statistics used to measure any or all expenses. The proposed budget must cover the first two full years of operation after the completion of the project. For example:

	Project	Projection	
Current Year	Completion Date	First Year	Second Year
2003	March, 2004	2005	2006

2. If an operating loss is projected in the second year after project implementation, please explain how the operating loss will be covered.

3. Projections also must include all prior Certificate of Need applications which have either been approved or for which approval is anticipated. Identify by Certificate of Need Number, the Certificates of Need included in the projected expenditures and statistics.

4. Projections must include increases due to projects because of any or all of the following:

   a) Salaries
   b) Supplies and Expenses
   c) Leases
   d) Debt Obligations (Interest and Depreciation)

5. If there are to be any cost savings to the facility as a result of this project, attach a schedule of these savings.

6. Use current dollars and omit 000's.

* This shall include all licensed long term care beds at the site the project proposed in this application will be implemented and shall include all long term care beds proposed in this application.

Name of Facility

	General Long Term Care		Specialized Long Term Care	
	Year Ending 20__	Year Ending 20__	Year Ending 20__	Year Ending 20__
Revenue				
Total Revenue				
Expenses (operating and non-operating)				
Administration				
Health Care Services (Total)				
Salaries				
Professional Fees				
Rental of Equipment				
Supplies				
Drugs				
Other (specify and explain):				
_____				
_____				
Dietary				
Laundry and Linen				
Housekeeping				
Plant Operation and Maintenance				
Miscellaneous (specify and explain):				
_____				
_____				
Total Expenses				
Total Resident Days				
Cost Per Resident Day				
Net Income/Loss	$	$	$	$

Name of Facility

J. APPLICANT'S COMMITMENT TO ASSURING ACCESS TO CARE FOR LOW INCOME AND FORMER PSYCHIATRIC PATIENTS AND/OR RESIDENTS:

As a condition of certificate of need approval, I agree to the following commitments to assure access to long term care services for low income and former psychiatric patients and/or residents:

	General Long Term Care	Specialized Long Term Care (Ventilator)	Specialized Long Term Care (Behavior Management)	Specialized Long Term Care (Pediatric)
% Direct Medicaid Occupancy				
% Overall Medicaid Occupancy				
% Supplemental Security Income Recipient Occupancy				
% Discharged Psychiatric Patients				

NOTE: The percentages stated by the applicant in Section J above must be utilized in the revenue statistics in Sections E, F, G and H.

K. PROJECTED STAFFING LEVELS:

1. Provide a list of the type, number of Full Time Equivalents (FTE's) and estimated annual salary of the personnel required to staff the new or expanded facility and identify the sources from which you intend to obtain the required personnel. Submit a separate page for each health care component.

Department	Job Title	Estimated Annual Salary (non-fringed)	Number of FTE's	Sources of Personnel

2. What strategies will be employed to recruit and retain health care staff? (Attach an additional page and identify it as Item K. 2., if necessary.)

Name of Facility

L. PROJECT NARRATIVE

Respond to all statements specified in Section II referenced to the corresponding items in Section II.

M. REQUIRED DOCUMENTS

Submit all required documents specified in Section III referenced to the corresponding items in Section III.

N. ASSURANCES:

By signing this application, the applicant gives assurance that:

1. The attached statements and schedules are complete and correct to the best of the applicant's knowledge and belief.

2. If approved, the applicant will submit to the Commissioner of Health of the State of New Jersey for prior approval changes in scope of work, cost, or function.

3. If acquisition is by construction of a facility, the applicant will obtain the approval of the State of New Jersey, Department of Health of the final working drawings and specifications, which shall conform to the general standards of construction and equipment, prior to the making of contracts. The applicant will also provide and maintain competent and adequate supervision and inspection to ensure that the completed work is in conformance with the application and approved plans and specifications.

4. The facility will be operated and maintained in accordance with the standards prescribed by law for the maintenance and operation of such facilities.

Name of Applicant (Operator/License Holder) (Print or Type)		
Name of Responsible Officer (Print or Type)	Title	
Signature		Date

Name of Facility

APPLICANT CHECKLIST

☐ Application fee in the amount of $_____

☐ Track record report for all out-of-state facilities included.

☐ All applicable pages of the application completed.

☐ Copy of Certified Financial Statement included.

☐ All applicable statutory and regulatory criteria addressed.

☐ Application signed and dated by applicant.

APPENDIX A

Name and Address of
Out of State Agency

Re: (Name of Project)

Dear Sir:

(Name of Applicant) is submitting a Certificate of Need (CN) application in the State of New Jersey to (Project Description)

This application requires us to identify all health care facilities which we own, operate or manage. In (State) we listed the following facility(ies):

As part of its review process, the New Jersey Department of Health is requesting information regarding the licensing status of the facility(ies) and any enforcement action against the facility(ies) within the last year. In addition, the Department would like to know, based on your experience with this corporation, if you can recommend the owners as responsible operators. A brief statement supporting your recommendation should also be included.

Please reference our proposed New Jersey project in your response, and forward the response to me. (Name of Applicant) will be submitting this CN application to the State of New Jersey on (date) . Track record information must accompany the CN application. Therefore, (Name of Applicant) will appreciate receiving your response by (date) .

Thank you for your cooperation.

Sincerely,

cc: NJDOH

SCHEDULE A

Name of Facility	Certificate of Need Number	Date

Location (Building/Wing/Floor)	Project Description *	Current Problem Code **	Areas		Gross Square Feet	Construction Cost Breakdown
			Current Use	Proposed Use		

* Identify Renovation (REN) or Demolition (DEM). Following the identification of Renovations (REN), indicate the associated scope of work as Minor (MIN), Moderate (MOD), or Major (MAJ). (For example, use REN-MIN, or REN-MAJ.)

** Problem Codes:

1 – Life Safety Code Deficiencies (per NFPA 101 Life Safety Code
2 – Undersized/Non-Compliant Area [per current Licensure Standards and AIA Guidelines for Construction and Equipment of Hospital and Medical Facilities (current Edition in effect)]
3 – Non-Compliant Functional Design Layout
4 – Overall Physical Plant Age Obsolescence
5 – Other – Specify
6 – Uniform Fire Code, State of New Jersey