**New Jersey Department of Health**

**CERTIFICATE OF NEED APPLICATION - EXPEDITED REVIEW**
**FOR FACILITIES AND SERVICES IDENTIFIED AT N.J.A.C. 8:33-5.1(a)**

**GENERAL INFORMATION**

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1. Applications shall be accepted on the first business day of the month. Applications submitted after the first business day of the month shall be processed in the next cycle (e.g., an application submitted on February 4, 1997, would be processed in the March 3, 1997 cycle; the 90-day review period would not begin to run until March 3, 1997). Requests for exceptions to this policy will not be entertained.

2. All applicants must complete Sections I, II and VI. In addition, applicants for a change in cost or financing must complete Section III, applicants seeking to establish or change the operating room capacity of an ambulatory surgery facility must complete Section IV, and applicants seeking an extension of time must complete Section V.

3. All applications must be accompanied by an application fee, consistent with the fee schedule below. The application fee must be in the form of a certified check, cashier's check or money order, and should be made payable to *"Treasurer, State of New Jersey."*

| **FEE SCHEDULE:** | | **Fee Required** |
|---|---|---|
| A. | Establishment of a facility or service (except hospital sub-acute care units); change in the capacity of an existing facility or service (except hospital sub-acute care units); acquisition or replacement or major moveable equipment with a Total Project Cost (TPC) of: | |
| | $1,000,000 or Less | $7,500 |
| | Greater than $1,000,000 | $7,500 + 0.25% of Total Project Cost |
| B. | Change in Scope or Location | $7,500 + 0.25% of cost in excess of approved TPC, where excess is $1,000,000 or more |
| C. | Change in Cost | No Certificate of Need required; 0.25% of cost in excess of approved TPC, where excess is $1,000,000 or more, shall be remitted prior to licensure |
| D. | Extension of Time | $7,500 |
| E. | Transfer of Ownership (General Hospital) | $7,500 |

4. All applications must be signed and dated by the applicant, accompanied by the correct application fee, accompanied by out-of-state track record reports (if applicable), and completely and accurately filled out (i.e., no partial or unresponsive answers). APPLICATIONS NOT MEETING THESE REQUIREMENTS WILL NOT BE ACCEPTED FOR PROCESSING. APPLICANTS WHOSE APPLICATIONS HAVE NOT BEEN ACCEPTED FOR PROCESSING MAY SUBMIT A NEW APPLICATION IN ANY SUBSEQUENT REVIEW CYCLE.

5. Applications may not be altered or modified by an applicant unless such alteration or modification is solicited by Department of Health staff.

## GENERAL INFORMATION
**(Continued)**

6. One completed application in electronic media and ten paper copies of the application and supporting documentation, along with the appropriate application fee, should be submitted 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
   25 South Stockton Street, 2nd Floor
   Trenton, NJ 08608-1832

7. Regulations governing the expedited review process may be found at N.J.A.C. 8:33-5.1 through 5.4. Applicants requiring additional information or assistance should contact Department staff at (609) 292-5960 or (609) 292-6552.

8. If new construction and/or renovations ARE required subsequent to certificate of need approval, architectural plans must be submitted to the Department of Community Affairs, Division of Codes and Standards, Health Care Plan Review, PO Box 815, Trenton, NJ 08625-0815. You may not proceed with any construction or renovations until you have received final construction plans approval.

9. If new construction and/or renovations ARE NOT required, a floor plan of the facility must be submitted WITH THE CERTIFICATE OF NEED APPLICATION. This plan shall indicate the dimensions and use of each room, door swing direction, corridor widths, exit locations, and locations of all toilets and sinks. You must also note whether the bathrooms and premises are handicapped accessible, in accordance with the latest ADA requirements. You must also submit documentation that the existing unit complies with applicable fire signaling systems and egress requirements and note locations of pull stations, emergency fixtures, and fire extinguisher locations on the plan.

10. For all applications to relocate nursing home beds from one county to another, you must complete Section V “Long Term Care Bed Relocation” questions.

**New Jersey Department of Health**

# CERTIFICATE OF NEED APPLICATION - EXPEDITED REVIEW FOR FACILITIES AND SERVICES IDENTIFIED AT N.J.A.C. 8:33-5.1(a)

| FOR STATE USE ONLY | | | |
|---|---|---|---|
| Date Received | Application Fee | Cycle | Application Number |

Project Category (Check only one)

- ☐ Establishment of a facility or service
- ☐ Change in the capacity of an existing facility or service
- ☐ Extension of time (CN# _____ )
- ☐ Acquisition or replacement of major movable equipment
- ☐ Change in cost, scope or financing (CN# _____ )

Type of Facility or Service (Check only one)

***PLEASE NOTE that, with the exception noted below (*), applications for facilities or services not specifically identified at N.J.A.C. 8:33-5.1(a) will not be accepted for processing.***

- ☐ Assisted Living Program *****
- ☐ Assisted Living Residence
- ☐ Comprehensive Personal Care Home
- ☐ Hyperbaric Chamber Service
- ☐ Statewide Restricted Admissions Facility

## SECTION I

| | | |
|---|---|---|
| Name of Applicant | | ☐ Profit ☐ Non-Profit |
| Name of Applicant's Authorized Representative (if applicable) | Title of Authorized Representative | |
| Street Address | | Telephone Number ( ) |
| City, State, Zip Code | | Fax Number ( ) |
| Name of Contact Person | | Telephone Number (if different from above) ( ) |
| Name of Facility or Proposed Facility | | |
| Facility Address | | Telephone Number ( ) |
| City, State, Zip Code | | Fax Number ( ) |
| County | Municipality/Township | Lot and Block Number |

## SECTION II

1. If the applicant is a for-profit entity, identify 100% of the ownership of the facility or service, identifying each principal by name, address and percentage of ownership. If the facility or service is owned by a publicly held corporation, please identify each principal who holds a 10% or greater interest. Attach additional sheets as necessary. If the applicant is a not-for-profit entity, proceed to Question 2.

| Name of Principal | Address | % of Interest |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

2. Identify all licensed health care facilities, both in New Jersey and in any other state, which are owned, operated or managed by the applicant or any corporate entity related to the applicant (e.g., parent or subsidiaries). Identify the complete name of the facility, the city and state in which the facility is located, and the Medicare Provider Number. If licensed out-of-state facilities are listed, please submit track record reports, for the preceding 12 months, from the respective state agencies responsible for licensed health care facilities, proceed to Question 4.

| Name of Facility | Address (City and State) | Medicare Provider Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

3. If New Jersey facilities are identified in Question 2 above, indicate whether each facility is in compliance with certificate of need conditions of approval. If any facility is not in compliance, please attach a detailed explanation.

| Name of Facility | Certificate of Need Number | Yes | No |
|---|---|---|---|
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |

4. Identify the total project cost and the project funding source(s).

_____ Funding Sources: 1) _____
2) _____
3) _____
4) _____

5. For the 12-month period immediately following licensure of the proposed facility or service, please provide estimates of:

a. Total Operating Costs $ _____
b. Total Revenues $ _____
c. Utilization Statistics (Attach as Appendix A)

**SECTION II, Continued**

6. Briefly describe the proposed facility or service (e.g., "This project involves the addition of one same day surgery room to the XYZ Ambulatory Surgical Facility, which is presently licensed to operate one same day surgery room."), being certain to identify any changes in square footage and/or equipment.

_____
_____
_____
_____
_____

If the proposed project involves beds, please specify the number and type of beds to be established, added and/or reduced.

| | Number | Type |
|---|---|---|
| a. Newly Established: | _____ | _____ |
| b. Addition to Existing: | _____ | _____ |
| c. Reduction to Existing: | _____ | _____ |

7. Identify all components of the proposed project by which you intend to ensure that residents of the surrounding area, particularly the medically under-served, will have access to the proposed facility or service.

_____
_____
_____
_____
_____

8. Explain why the applicant believes that this facility or service is justified.

_____
_____
_____
_____
_____

9. Identify those area services which may be affected, both positively and negatively, by the approval of this application.

_____
_____
_____

10. Provide copies of last available project financial statements, balance sheets, income statements and cash flow statements. If a loss is projected in the first 12 months, please provide a second year income statement. Attach as "Appendix B."

## SECTION III
## (FOR CHANGE IN COST OR FINANCING APPLICANTS ONLY)

1. Original Total Project Cost $ _____ Revised Total Project Cost: $_____
2. Additional Capital Costs:
   a. Construction
      (1) New Construction $ _____
      (2) Demolition _____
      (3) Renovations _____
      (4) Asbestos Abatement _____
      (5) Architect and Engineer Fees _____
   b. Major Moveable Equipment _____
   c. All Other Capital Costs _____
   TOTAL NEW CAPITAL COSTS _____
   c. Utilization Statistics (Attach as Appendix A)
3. Additional Financing Costs:
   a. Capitalized Interest _____
   b. Debt Service Reserve Fund _____
   c. All Other Fees and/or Costs _____
   TOTAL ADDITIONAL FINANCING COSTS: _____
   TOTAL ADDITIONAL PROJECT COSTS (2 & 3): _____
4. Revised Total Project Financing Alignment:
   a. Equity Contributions _____
   b. Financing _____

## SECTION IV
## (FOR EXTENSION OF TIME APPLICANTS ONLY)

1 Describe, in detail, the facts and circumstances which you believe constitute "extraordinary unforeseeable circumstances beyond the control of the applicant," as required pursuant to N.J.A.C. 8:33-3.10(a)4, which would justify the grant of an extension of time. Include documentation regarding current status of the project, as well as reasons for delays and proposed detailed time frame identifying the remaining time needed for completion of the project. Attach additional sheets as necessary.

_____
_____
_____
_____
_____
_____
_____

## SECTION V
## (FOR LONG TERM CARE BED RELOCATION APPLICANTS ONLY)

Before the Department of Health may proceed with the review of your certificate of need, the questions listed below need to be addressed. Please be advised that an application will not be deemed complete unless this required information is provided.

| | County of Sending Facility | County of Receiving Facility |
|---|---|---|
| 1. *Current *(identify year)*: _____ 65 and Over Population | _____ | _____ |
| 2. *Projected 65 and Over Population in 3 Years | _____ | _____ |
| 3. *Rate of 65 and Over Population Growth | _____ | _____ |

* Identify data source.

4. Based on above, identify and discuss issues of access to long-term care beds for the 65 and over population in both counties:

5. Please describe in detail how the project cost is sufficient to implement the beds at the new site:

| Name of Person Completing this Section of the Application | Date |
|---|---|
| | |

| **SECTION VI** | |
|---|---|
| I hereby certify that, to the best of my knowledge, the above information is accurate. I understand that if the information supplied is knowingly inaccurate or fraudulent, any certificate of need or subsequent license granted as a result of the information contained herein may be revoked. In addition, I hereby acknowledge that the facility or service which is the subject of this certificate of need application must meet licensing and construction standards prior to a license being issued by the Department of Health. | |
| Name of Applicant or Applicant's Authorized Representative (type or print) | |
| Signature | Date |