APPENDIX C

New Jersey Department of Health

CERTIFICATE OF NEED APPLICATIONS FOR HOSPITAL-RELATED PROJECTS

SECTION I. GENERAL REQUIREMENTS

1. CERTIFICATE OF NEED

A. PRE-SUBMISSION

Prior to the preparation of the application materials, it is strongly recommended that the applicant discuss the proposed project with the local advisory board in the service area presently served or anticipated and staff of the New Jersey Department of Health.

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
171 Jersey Street, Building 5, 1st Floor
Trenton, NJ 08611-2425

C. SIGNATURE

All applications must be signed by the current Chief Administrative Officer or Board Chairman of the Hospital.

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 may result in rejection of the application.

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
	Transfer of Ownership	$7,500
	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

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. All exhibits 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 the appropriate section.

4. Identify each response in the narrative section 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."

5. Only complete applications will be processed (NJAC 8:33-4.5). 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.

7. Change in cost/scope applications shall request in writing a construction cost allowance prior to submission of the change in cost/scope application.

8. All applications must be signed and dated by the applicant, accompanied by the correct application fee, accompanied by out-of-state track records 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.

F. MODIFICATION

1. Under no circumstances may an application be modified or altered to change the number or category of inpatient beds, proposed services, equipment subject to a planning regulation, or change in site after the application submission deadline date. An applicant desiring to make such a modification or alteration shall be required to withdraw the application from the current cycle and submit a new application for the next cycle.

2. Modifications not specified in (1) above such as changes in square footage and change in cost will be permitted if such changes are in response to completeness questions from the Department and made prior to submission of the application to the review process.

2. LICENSING

Licensing manuals for hospital-based services may be obtained from the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure (609-292-5960).

3. FINANCIAL

Information with regard to financial requirements may be obtained from the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure (609-292-5960).

4. CONSTRUCTION

Information regarding construction requirements may be obtained from the New Jersey Department of Community Affairs, Division of Codes and Standards, Health Care Plan Review (609 633-8153).

SECTION II. REQUIREMENTS FOR COMPLETION OF NARRATIVE SECTION (F AND M) OF CERTIFICATE OF NEED APPLICATION

1. STATE HEALTH PLANNING REQUIREMENTS

A. DESCRIPTION / PROJECT NARRATIVE

1. Provide an executive summary of the project (Section F). This shall be limited to 3 pages.

2. Describe the proposed project, in detail, and relate it to existing services such as changes in square footage, changes in equipment, deficiencies corrected, effect on length of stay, improved patient care, reduced cost, and improved patient safety.

3. Provide historical hospital volume data incorporating the last three complete calendar years preceding the date of filing the certificate of need application, as well as year-to-date data for the current year, and at a minimum include the following data components:

   a. Inpatient admissions by licensed bed category and total hospital (exclude same day surgery);

   b. Adjusted admissions by total hospital;

   c. Patient days by licensed bed category and total hospital;

   d. Outpatient visits by department or service;

   e. Emergency room visits;

   f. Inpatient surgical procedures;

   g. Outpatient surgical procedures;

   h. Same day surgery;

   i. Same day medical admissions;

   j. Births;

   k. Year-to-date B-2 forms showing inpatient utilization for current year.

4. Provide an estimate of projected volume in all categories as listed in #3 above for each year inclusive from the time of application to that year which is two complete calendar years beyond estimated project completion. This estimate must be based upon historical data found in #3 above. using at a minimum, a straight-line projection and one or more of the following methodologies:

   a. Linear regression modeling;

   b. Constant volume;

   c. Official county-based volume projections and market share statistics published by the Department, if available;

   d. A methodology chosen by the applicant, but in each instance the assumptions utilized in making the projections must be clearly substantiated in the application.

5. Describe the present and anticipated need for the project in the hospital's service area using the historical and projected volume data provided in questions #3 and #4.

6. List all other institutions in your service area that provide similar services. Indicate the anticipated impact of this project on these other institutions.

7. Document the institution's past and current history in providing care to the indigent and how the proposed project will affect the applicant's ability to provide care for the indigent.

8. In the case of a reduction, elimination or relocation of a facility or service, describe the need that the population presently has for the service; as well as the extent to which that need will be met after the change, including alternative arrangements. Describe the effect of any reduction, elimination, or relocation on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other under-served groups to obtain needed health care.

9. Identify alternative approaches to the project which were considered and demonstrate in specific terms how the option selected, relative to all other alternatives, most effectively benefits the health care system through achieving capital and operating savings, increasing access, and/or improving quality of care.

10. Efficient design is encouraged to promote significant life cycle operational cost savings. If the project involves new construction please identify operational cost savings which may result from such construction.

11. Indicate the conformance of the proposed project, if applicable, with appropriate State guidelines and regulations. In the case of regional services (e.g., cardiac diagnostic and surgical services, perinatal services, organ transplantation services, etc.) each provision of the applicable rule must be addressed.

12. Attach a map of your patient service area including the location of your institution. Identify major service areas based on patient origin studies for inpatients and/or outpatients.

13. Provide a breakdown of total project costs into costs associated with each programmatic or functional component: i.e., by service, department, medical specialty, licensed bed category, or other logical category; and by floor or unit if possible (See Schedule A).

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

15. Identify (by certificate of need number and project description) all previously approved certificates of need which have not been completed and indicate the current status of each project.

16. Identify (by certificate of need number) any conditions of certificate of need approval which have not been met and explain.

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.

B. Provide proposed total "building gross square footage" of new construction. Indicate building's proposed design, number of stories and construction type. (Also see "H" if multiple areas are involved.)

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.

D. Provide total square footage of area proposed for renovations. 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. (Also see "H" if multiple areas are involved.)

E. Indicate any anticipated construction related circumstances and/or conditions (e.g.. asbestos, wetlands, CAFRA, fire suppression system) that may explain your new construction and/or renovation cost estimate being over or under an average estimate. Identify the associated cost effect anticipated.

F. Renovation projects involving asbestos abatement should provide the associated cost estimate as a separate line item, identifying the areas and total square/linear footage involved.

G. Provide description and/or listing of equipment items inclusive of the "fixed equipment not in construction contracts" line item(s) cost estimates (See pages 4, 5 and 6).

H. Projects with more than one department service area affected by new construction or renovations must complete Schedule A. Utilize a separate line item for each service area on a given floor/wing and for any change in use of an existing area. Square footage and construction/renovation hard cost totals of this form should reconcile with those amounts indicated on pages 1 and 2 of the Certificate of Need Application. Account for all displaced department service areas, relocations and vacated areas, even if there are no associated construction/renovation costs. (Change in cost/scope applicants are to provide update of space allocation forms previously submitted.) Indicate how this information was established.

I. 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.

J. In addition to the fire suppression system(s) that may be required by the State Uniform Construction Code, the proposed scope of work shall include those systems, as appropriate, after a review of N.J.A.C. 5:23-2.4 and 2.5, and in consideration that the Uniform Fire Code State of New Jersey will require that all hospitals be fully suppressed. Installation of compliant suppression system(s) and related construction cost(s) shall be included in the proposed project.

K. The following architectural prints shall be submitted to visually indicate the entire scope of work as described in the written narrative:

- Site plan showing building footprint(s) (graphically differentiating existing structures to remain, those to be demolished and new construction) and compass orientation.

- Floor Plan(s)-Projects $15 million and over:
(At 1/8" scale, single line showing door openings and windows, rooms/areas to be labeled to indicate use/service and numbered, new construction/renovation work to be graphically differentiated from existing work to remain).

- Projects under $15 million, 1/16" scale sketch.

L. Change in cost/scope applications, for which the project is already under construction, must submit a copy of the signed contract with the Contractor and Architect (if not previously submitted to the New Jersey Department of Community Affairs). A copy of the most recent Contractor Requisition for Payment (Form AIA-G702) must be submitted with cost/scope application in addition to a reconciliation summary statement of same to agree with the total construction/renovation cost requested in the cost/scope application, acknowledging all incurred and anticipated change orders.

M. For change in cost/scope applications, applicants are to itemize and explain all construction/ renovation related cost changes (increases and/or decreases), noting those that are attributed to additional expanded project scope which were not in original Certificate of Need, those attributed to overruns (broken down as unanticipated-unforeseen and/or unanticipated due to initial underestimate) and those related to deletion of any portion of the original approved project scope.

SECTION III. REQUIRED DOCUMENTS

1. CERTIFICATE OF NEED

A. SITE OPTION/LEASE

1. If the site is optioned by the applicant, a copy of the deed held by the current owner and option agreement for the site must be submitted.

2. If the real property will be leased by the license holder, provide a copy of the deed held by the current owner and executed lease agreement or lease option.

The deed and option must include identification of the site, terms of the agreement, date of execution and signatures of all parties to the transaction.

B. MANAGEMENT AGREEMENT

If a management company will be hired, a copy of the management agreement must be submitted with the application.

2. FINANCIAL FEASIBILITY STUDY

A. Financial feasibility study and facility planning studies must be submitted.

B. If financial resources for the project are monies from a grant, provide the Department with a copy of the operating budget submitted with supporting pages from the grant application 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.

C. If financial resources for the project and/or monies for the operating 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.

D. If financial resources for the project and/or monies for the operating 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.

E. Independent third-party verification of the availability of the cash equity contribution must be submitted with the application. Provide the specific source and any available documentation demonstrating the availability of the cash equity contribution. Acceptable forms of verification include letters from banks, CPA's or stockbrokers, past history of fund-raising activity, and documented pledges.

F. For projects exceeding $15,000,000 in cost, institutions must submit to the Department independently verified historical and projected financial and utilization information as identified in N.J.A.C. 8:33-4.10(b) (1-6). This information should be in the format required by the New Jersey Health Care Facilities Financing Authority so that only revisions to update the information will be required at the time of financing.

3. CONSTRUCTION

A construction cost and space breakdown report must be submitted with any application involving construction. The report must be in the same format as Schedule A.

New Jersey Department of Health

APPLICATION - CERTIFICATE OF NEED FOR HOSPITAL-RELATED PROJECTS

Name of Hospital	**FOR STATE USE ONLY**
Street Address	Appl. No. _____
City State Zip Code	Review Cycle _____
County	Type of C/N:
Type of Hospital	☐ Change in Bed Capacity
Name of Chief Executive Officer	☐ New Health Care Service
Name of Contact Person	☐ Modernization/Renovation
Title	☐ Major Movable Equipment
Telephone Number	☐ Construction/Acquisition
	Date Received: _____

A. Project Cost:

1. Total Capital Cost: _____
2. Financing Cost: _____ Method of Financing: _____
3. Total Project Cost (1 + 2): _____
4. Equity Contribution: _____
5. Construction Cost:

Type	Square Feet	Construction/ Capital Lease Cost	Construction/ Capital Lease Cost Per Square Foot
New Construction			
Renovation			
Lease			

6. Will this project result in any permanent change in licensed or planning bed category or capacity of the existing facility?
   ☐Yes ☐No

7. Provide a brief (50 words) description of the project:

B. PROJECT COST

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.

Do not include contingency. The Department will calculate a construction cost allowance for the project in lieu of providing a contingency factor for the time period from Certificate of Need submission to the start of construction.

1. Capital Costs

Studies and/or Surveys		
Site Survey and Soil Investigation		
Architect and Engineer Fees		
Legal and Other Special Services		
Plans and Specifications		
Demolition		
Renovations		
Asbestos Abatement		
New Construction		
Fixed Equipment Not in Construction Contracts (New Construction)		
Fixed Equipment Not in Construction Contracts (Renovations)		
Major Movable Equipment		
Supervision and Inspection of Site and Building(s)		
Purchase of Land		
Purchase of Building(s)		
Capital Value of Lease (true operating leases should be included in operating budget and details identified)		
Developmental and/or Start-Up Costs		
Department of Health Approved Construction Cost Allowance		
Other (Specify) (Do NOT include contingency)		
_____		
_____		
_____		
Total Capital Costs		

2. Financing Costs

Capitalized Interest		
Debt Service Reserve Fund		
Other Financing Costs (Include fees assessed by any financing agency, bond counsel fees, trustees bank fees and/or other costs related to sale of bonds)		
Total Financing Costs		
Total Project Cost		

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 fifteen percent (15%) of the total project cost, including all financing and carrying costs, must be available in the form of equity.

1. Available Cash (include source of contribution in D-1) $ _____
2. Mortgage (provide details in D-2) _____
3. Loans (provide details in D-2) _____
4. Capital Leases (provide details in D-2) _____
5. Net fund raising (include documentation) _____
6. Other (Specify)

_____ _____

_____ _____

_____ _____

Total $ _____

D. EQUITY CONTRIBUTION

1. Indicate source of equity contribution:

2. Mortgages/Loans/Capital Lease Agreements - Attach a copy of any mortgage, loan or capital lease agreements.

Lender/Lending Institution	Amount	Rate of Interest	Annual Payment	Maturity Date
New Construction				
Renovation				
Lease				

E. EQUIPMENT

1. Major Moveable Equipment

Qty.	Description	Addition/ Replacement	Purchase/ Lease/ Donation	Total Purchase Cost/ Donation	Annual Lease Cost
TOTAL					

E. EQUIPMENT

2. Fixed Equipment

Qty.	Description	Addition/ Replacement	Purchase/ Lease/ Donation	Total Purchase Cost/ Donation	Annual Lease Cost
TOTAL					

E. EQUIPMENT

3. Minor Moveable Equipment (For information purposes only; do not include in project cost.)

Qty.	Description	Addition/ Replacement	Purchase/ Lease/ Donation	Total Purchase Cost/ Donation	Annual Lease Cost
TOTAL					

F. PROJECT SUMMARY

(A written summary of your project is required. Please do so on Pages 7 through 9 of the Certificate of Need Application form. The summary must be comprehensive and not exceed three pages.

F. PROJECT SUMMARY, Continued

F. PROJECT SUMMARY, Continued

G. GRANTS

Attach a copy of grant budget submitted.

Source	Amount	Current Status of Grant
TOTAL		

H. VOLUME OF ACTIVITY IN COST CENTERS RELATED TO PROJECT

1. Admissions or Cases

Routine and Emergency Service	Current Year	Projected Year 1	Projected Year 2
Medical/Surgical Admissions *			
Same Day Surgery Admissions			
Pediatric			
Acute Psychiatric			
Long-Term Psychiatric			
Obstetric			
Burn Unit			
Intensive Care Unit			
Neonatal Intensive Care			
Coronary Care Unit			
Newborn Nursery			
TOTAL			

*Exclude Same Day Surgery Admissions.

2. Visits

Cost Center	Current Year	Projected Year 1	Projected Year 2
Emergency Room			
Clinic			
Private Outpatient			

I. OPERATING PROJECTIONS

1. Revenues (Report in 000's):

Category	2 Most Recent Actual Years Ended (Audited)		Current Year Projection	Projected Years Ending (Through Second Year After Project Completion)			
Inpatient Services							
Outpatient Services							
Total Patient Service Revenues							
Allowance for Charity Care							
Contractual Allowances							
Net Patient Service Revenues							
Other Operating Revenues							
Total Net Operating Revenues							

2. Expenses (Report in 000's):

Category	2 Most Recent Actual Years Ended (Audited)		Current Year Projection	Projected Years Ending (Through Second Year After Project Completion)			
Salaries, Wages & Professional Fees (Including Contracted Services and Fringe Benefits)							
Interest:	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /
a. Current Interest							
b. Project Interest							
c. Total Interest							
Depreciation:	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /
a. Current Depreciation							
b. Project Depreciation							
c. Total Depreciation							
Bad Debt Provision							
Supplies and Other Expenses							
Total Operating Expenses							
Net Income From Operation							
Non-Operating Income							
Surplus (or Deficit)							

3. Patient Mix by Sources of Revenue (Report in 000's):

Category	2 Most Recent Actual Years Ended (Audited)		Current Year Projection	Projected Years Ending (Through Second Year After Project Completion)			
Medicare							
Medicaid							
Blue Cross							
Commercial Insurance							
Self-Pay							
Indigent							
Other							
Total Patient Service Revenue	100%	100%	100%	100%	100%	100%	100%

J. PROJECTED STAFFING LEVELS

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 source from which you intend to obtain the required personnel. (Compute FTE based on 2,080 annual hours per employee.)

Personnel Category		Estimated Annual Salary	Number of FTE's	Sources of Personnel	Additional Personnel To Be Hired
Department	Job Title				

K. ACCESS TO SERVICES

1. Was your facility, or a portion thereof, constructed with Hill-Burton funds?

☐Yes ☐No

2. Indicate the percentage of uncompensated care provided annually for inpatient and outpatient services:

a. Inpatient Mortgage (provide details in D-2) _____ %

b. Outpatient _____ %

3. What is the number of physicians with admitting privileges at your facility?

_____

4. What is the number of physicians with admitting privileges who admit Medicaid patients to your facility?

_____

5. Does your facility require a pre-admission deposit?

☐Yes ☐No

a. If Yes, explain: _____

_____

_____

6. Clinic Services (Exclude Private Outpatient Visits):

Type	Hours/Days Per Week of Operation	Patient Visits/Week
General Medical		
Surgery		
Cardiac		
Prenatal		
Pediatric		
Psychiatric		
Post-Partum		
Other:		

L. BED AND SERVICE INVENTORIES

1. Bed Inventory:

Bed Complement	Licensed Beds	C/N Approved But Not Licensed Beds	Proposed New Beds	Proposed Decrease in Beds	Total Beds After Project Completion
Medical/Surgical					
ICU/CCU					
Obstetric					
Pediatric					
Psychiatric (All categories)					
Comprehensive Rehabilitation					
Long Term Care					
Other:					

2. Psychiatric Beds by Category:

Bed Category	Existing Beds	Increase	Decrease	Total Beds After Project Completion
Adult Open Acute				
Adult Closed Acute				
Adult Closed Acute				
Adult Intermediate				
Adult Special				
Adult MICA				
Adult Geriatric				
Adult Eating Disorder				
Child and Adolescent Acute				
Child and Adolescent Intermediate				
Undesignated				
Total				

3. Service Inventory:

Cardiac Services	Number Existing	C/N Approved But Not Implemented	Total After Project Completion
Cardiac Diagnostic Services - Catheterization Labs - Adult			
Cardiac Diagnostic Services - Catheterization Labs - Pediatric			
Cardiac Diagnostic Services - E.P.S. Labs			
Cardiac Surgery Operating Rooms			

Renal Services	Number of Existing Stations	C/N Approved But Not Implemented	Total After Project Completion
Acute Stations			
ESRD Chronic Hemodialysis Stations			
Peritoneal Stations			
Isolation Stations			
Training Stations			

Surgical Services	Number of Existing Operating Rooms	C/N Approved But Not Implemented	Total After Project Completion
Dedicated Inpatient Operating Rooms			
Dedicated SDS			
Mixed Inpatient / SDS			
Cardiac			

Trauma Services
☐ Level I
☐ Level II
☐ None

3. Service Inventory, Continued:

Perinatal Services	Existing	Proposed
Regional Perinatal Center - Normal Newborn Bassinets		
Regional Perinatal Center - Intermediate Neonatal Bassinets		
Regional Perinatal Center - Intensive Neonatal Bassinets		
Community Perinatal Center - Birthing Center Bassinets		
Community Perinatal Center - Normal Bassinets		
Community Perinatal Center - Intermediate Bassinets		
Community Perinatal Center - Intensive Bassinets		
Obstetric Bed Categories - LDR		
Obstetric Bed Categories - LDRP		
Obstetric Bed Categories - Post Partum		

M. PROJECT NARRATIVE

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

N. REQUIRED DOCUMENTS

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

O. ASSURANCES

The applicant gives assurance that the attached statements and tables are complete and correct to the best of the applicant's knowledge and belief.

Name of Responsible Officer	Title
Signature	Date

SCHEDULE A

Name of Facility	Certificate of Need Number	Date

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

* Identify as New Construction (NEW), 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, REN-MOD, 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

*** For new construction, provide breakdown in terms of proposed Building Gross Square Feet.

SCHEDULE B

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 licensing those facilities. Attach additional sheets as necessary.

Name and Address of Facility	**Medicare Provider Number**